Mental Health Standards of Care (Wales) Bill

Consultation 1: Summary of Responses

April 2024

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The proposed Mental Health Standards of Care (Wales) Bill seeks to replace outdated mental health legislation; improve the delivery of mental health plans for Child and Adolescent Mental Health Services and adult services in Wales; improve the accountability of Welsh public sector organisations; help to establish parity between the treatment of physical and mental health; and help to reduce mental health stigma in Wales.

The proposals aim to ensure that individuals are more empowered, have more choice and influence over their treatment, and receive the dignity and respect they deserve. They also aim to strengthen the patient voice.

To achieve these policy objectives, the proposed Bill will bring forward appropriate changes to the Mental Health Act 1983 in Wales, and amend elements of the existing Mental Health (Wales) Measure 2010.

This initial consultation sought views on the policy objectives of the proposed Bill. The consultation ran from 2 February 2024 to 22 March 2024.

32 responses were received in total from a range of organisations (26 responses) and individuals (6 responses). Organisations submitting responses included mental health and children's charities, professional bodies (healthcare and legal), NHS organisations, local government, the Public Services Ombudsman, and Children's Commissioner. A full list of respondents is included at Annex A.

This document provides a summary of the key issues raised; it is not intended to be an exhaustive account of every comment. Respondents' full comments can be found in their published responses to the consultation.

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1. The need for this legislation

There was broad agreement that **existing mental health legislation is outdated** and in need of reform. A number of respondents highlighted that the Mental Health Act 1983 has a **disproportionate, negative impact on some groups** (particularly black and ethnic minority groups, and also people with learning disabilities and neurodivergent people).

There was **significant support for the proposed legislation** and its rights-based, person-centred approach. Some respondents noted their disappointment that Mental Health Act reform was not being progressed at UK level. A number of responses described the proposals as an **opportunity for Wales to take the lead** in making much-needed improvements to standards of mental health care.

The mental health charity Adferiad (MHB023) said it had long called for new and strengthened mental health legislation for Wales:

> *We think it is timely to strengthen mental health legislation in Wales given that the previously proposed Mental Health Bill, designed to strengthen patients' rights, was not included in the Kings Speech in November 2023. […]*
>
> *We think this Bill provides an excellent opportunity to strengthen and amend Wales' pioneering Mental Health (Wales) Measure ('the Measure'), and that as well as introducing amendments to the Measure through this Bill, there is also an opportunity to introduce new regulations and to update the current codes of practice for Wales that relate to both the Measure and the Mental Health Act.*

The Public Services Ombudsman for Wales (MHB022) told us:

> *I am generally supportive of the overall purpose the Mental Health Standards of Care Bill is seeking to achieve where patients are more empowered, have more choice and influence over their treatment and receive the dignity and respect they deserve, where this leads to less injustice and maladministration.*

Digital Health and Care Wales (DHCW) (MHB007) said:

> *Good to see Wales leading the way on much needed reform of mental health services. This change in legislation will help promote a user centred approach when delivering mental health services, resulting in strengthening the patient's voice, to enable individual needs to be met.*

The Welsh Local Government Association (WLGA) (MHB019) also suggested this is an opportunity to align mental health law with other key legislation in Wales:

> *We can see the benefit of the proposed legislation to bring the powers under the 1983 Act more in line with the Wellbeing of Future Generations (Wales) Act 2015 and the Social Services and Wellbeing (Wales) Act 2014, as well as Children's Rights and Equalities legislation.*

While there was widespread support for the aims of the proposed legislation, a number of respondents highlighted **potential barriers to its effective implementation**. These are discussed further in the sections following and mainly relate to:

- the **cross-border implications** of different rights/legislation applying in Wales and England;
- the need for adequate **resourcing of mental health services** (including inpatient facilities and community-based services), and;
- the need for greater **clarity and detail** about the provisions and how they'll apply in practice.

2. Overarching principles

There was **broad, general agreement with the overarching principles** of: choice and autonomy; least restriction; therapeutic benefit, and; the person as an individual, and support for enshrining these in legislation.

The All Wales Deaf Mental Health and Well-Being Group (MHB009) told us:

> *We are aware of many examples in Wales where these principles are not adhered to by services, meaning a challenging, inadequate and disappointing patient experience. Sadly this often leads to people not seeking help, meaning*

> *not having treatment and being at increased risk of their mental health problems deteriorating further.*

An individual responding in both a professional and personal capacity (MHB010) described:

> *huge variability in the quality of care and the expertise of professionals in positions of considerable authority and power over people's lives. […] these principles should be at the heart of all health care. The challenge is to ensure that they are embedded in every professional's working practice.*

Mind Cymru (MHB017) said:

> *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).*

Some respondents called for the principles to be **included on the face of the legislation** (see MHB023, MHB032). Whereas Hywel Dda University Health Board (MHB005) suggested they should be **set out in the relevant code of practice** for Wales:

> *We agree with the principles and assume that they would sit within the Code of Practice for Wales and not within the MHA [Mental Health Act] as they would need to apply to both Countries.*

Some responses highlighted that these principles already exist (for example in guidance) but the extent to which they are applied in practice is unclear. A number of respondents questioned how adherence to the principles would be **measured and monitored**, and called for a strengthened system of **accountability** for the delivery of person-centred care.

Cardiff and Vale University Health Board (MHB016) told us:

> *the principles themselves are sound. However, there are similar principles already in place within Welsh Government legislation. Existing legislation should already be giving patients the same rights, yet that is not happening. I am not confident the new proposals will change the current situation unless those with a duty of care are held accountable.*

Similarly, All Wales People First (MHB018) said:

> *The proposal has to be enforceable in conjunction with real accountability otherwise it will make no difference to the current situation in Wales. The details look good on paper, but what will underpin success is a robust accountability on those who have a duty to deliver on these new standards.*

The Royal College of General Practitioners (RCGP) Cymru Wales (MHB027) suggested that practical guidance will be needed setting out how the principles should be applied in practice, highlighting the challenges in delivering crisis care outside a hospital setting:

> *as with any piece of primary legislation, further practical guidance will need to be providing as to how various healthcare professionals will be required to comply with these new statutory rights. RCGP Cymru Wales draws particular attention to the difficulties of administering crisis mental health care in the community where there will be increased risk factors compared with a hospital setting.*

The Welsh NHS Confederation (MHB028) called for person-centred language to be used throughout the bill and associated documentation (i.e. 'individual' or 'person' rather than 'patient'), in line with the principle of 'the person as an individual'.

3. Proposal to replace the Nearest Relative (NR) provisions in the Mental Health Act 1983 with a new role of Nominated Person?

There was **significant support for this proposal**, albeit with some caveats, with the vast majority of respondents agreeing that a new role of 'Nominated Person' should replace the Nearest Relative provisions in existing legislation.

The Royal Pharmaceutical Society (MHB012) for example said:

> *The change would empower individuals by giving them the opportunity to select the most appropriate person in light of their current circumstances. We agree that the current model of family involvement is outdated and insufficient.*

The Welsh Ambulance Services University NHS Trust (WAST) (MHB015) told us:

> *In these modern times families are more complex groups and enabling the patient to choose a nominated person (significant other) empowers them to have more control over their lives. Additionally people with mental health problems are more likely to have encountered adverse childhood experiences increasing the likelihood that their families are not the always the closest people in their lives.*

DHCW (MHB007), among others, emphasised the point that:

> *It should not be automatically assumed that the Nearest Relative is acting in the best interest of the patient. Changing legislation to a Nominated Person reinforces the user centred approach.*

One respondent strongly disagreed with the proposal, highlighting the **importance of the family's role** and their extensive knowledge of the individual and their mental health history. Others suggested the Nominated Person role should be **in addition to, but should not replace, the role of Nearest Relative**.

An individual with lived experience of **supporting family members with mental health difficulties** (MHB002) explained:

> *In many cases it is family members who are initially concerned about a person's behaviour and mental health, and relatives are frequently involved in seeking help at a time of crisis. This, understandably, can result in stress, tension and discord within the whole family. The subject often misinterprets the family involvement as interference and disloyalty. This is evidenced by the frequency with which family members are the subject of violence from the person in crisis. This proposal would represent further exclusion of the family.*

One of the key caveats highlighted by those supportive of the change to Nominated Person was the need for a **robust safeguarding process** to mitigate risks of exploitation and/or coercion.

Age Cymru (MHB014) for example told us:

> *People receiving treatment for mental health conditions can be vulnerable to abuse, and it is important to ensure that patients are not pressured into*

> *nominating someone who may abuse their trust and act against their best interests.*

Some particular safeguarding concerns were raised in relation to **children and young people**. Barnardo's Cymru (MHB024) called for greater clarity on the process for children and young people:

> *For example, how would this process be supported for children and young people to make the right decision for them? Would there be an age limit to nominate or change Nominated Person? What safeguarding provisions would be included in this decision? [...] It is also vital to understand to what extent this nomination would be extended to children and young people in the care of the local authority?*

A key theme was the need for further consideration about **how the Nominated Person provisions would work in practice**. Questions raised by respondents included:

- how would the nominated person information be recorded, and accessed by relevant parties at times of crisis?
- what would happen in situations where an individual hasn't previously identified a Nominated Person and they're assessed as lacking capacity?
- how would this work where people frequently wish to change their Nominated Person (for example, due to their lifestyle or mental state)?
- how will this align with any Lasting Power of Attorney in place?
- how would this apply in cross-border situations?

The WLGA (MHB019) for example said:

> *There will be a need to consider how the Nominated Person provisions will work. How will this be agreed and by whom. Will there be a need for a list to be maintained and how would this be monitored, maintained and how details of the Nominated Person will be shared and accessed at times of crisis by health, social services or other professionals.*

Public Health Wales (MHB026) said:

> *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 in this situation 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.*

The Law Society (MHB032) suggested that the power to overrule or displace a nominated person should sit with the Mental Health Review Tribunal in Wales due to the specialist knowledge and experience of these tribunals.

A number of respondents highlighted potential **opportunities for people to identify their nominated person at an early point** (for example, for people who've had previous contact with mental health services, and including Nominated Persons in advance directives or care and treatment plans).

Public Health Wales (MHB026) for example suggested that:

> *Opportunities for people who have had previous contact with mental health services should be created for them to nominate a person during periods of capacity, such as during contact with primary care, community mental health or social care professionals.*

Cardiff Council (MHB031) suggested:

> *Having a NP [Nominated Person], written into an Advanced Directive or Care and Treatment Plan when the person is well enough to make that determination would be beneficial to the patient and help avoid situations where AMHPs [Approved Mental Health Professionals] consult with someone who may harm or with whom sharing information about a patient's mental health may harm them.*

RCGP Cymru Wales (MHB027) recommended that there should be guidance directing professionals to ask about an individual's Nominated Person when that individual first wishes to discuss their mental health:

> *This is similar to the approach taken in women's health settings, where a mandatory question about domestic violence is asked every time a patient accesses the service.*

4. Proposal to change 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

There was **broad agreement with the principle** that people should only be detained if they pose a risk of serious harm to themselves or others. A key point made by respondents was the need for a clear **definition of 'serious harm'** and agreed criteria for assessing risk.

Mind Cymru (MHB017) for example agreed that there needs to be 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.*

The British Psychological Society (MHB025) also said:

> *it is important that the legislation defines "serious harm" and includes in that definition both mental and physical harm.*

Swansea Council (MHB004) cautioned that:

> *Unless there is a nationally agreed criteria for assessing the degree of risk then this would be impractical and pose an undue burden on professionals.*

A number of respondents made the point that a potentially higher threshold for detention would mean **more support would need to be available in the community**.

Swansea Council (MHB004) for example went on to say:

> *The alternatives to admission and treatment are not available in the community to accept and manage people safely who were acutely ill at present. Without investment in community services which were well resourced and available to all then this would create a risk for many and be unsafe.*

The mental health and social change charity Platfform (MHB021) told us that:

> *we need to explore what options would then exist to support people in crisis or high levels of distress who need support, but do not meet the threshold for detention, or to whom detention would be harmful rather than therapeutic and would benefit from holistic and relationally (trauma) informed community treatment options. On that basis, we would encourage implementation of this Bill to be at a future date that provides services and communities time to develop support networks for people who will not meet a new threshold.*

Some responses highlighted that **detention isn't always a negative thing** as it can protect people from harm or prevent their mental health deteriorating. For example, the proposal could potentially lead to fewer detentions of people at risk of suicide or people whose mental health is deteriorating, leaving them to deteriorate further.

Cardiff Council (MHB031) told us:

> *Leaving a non-consenting patient in the community to deteriorate significantly until they present a risk of serious harm to themselves or others before using the Mental Health Act would have an adverse effect on their recovery and rehabilitation potential, leading to a poorer quality of life.*

The Welsh NHS Confederation (MHB028) said:

> *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.*

A small number of respondents queried whether changing the detention criteria could lead to situations where people are **denied treatment** if inpatient beds aren't available.

The Law Society (MHB032) for example said:

> *It is important that the change to the detention criteria, as well as the presumption that a person has capacity to decide on their own medical treatment, is not used to deny care and treatment to those seeking it. We believe the Code of Practice should make this clear.*

Some responses questioned how the proposed change to detention criteria would apply in **cross-border situations**.

Cardiff Council (MHB031) said:

> *For example how will this affect an application to an English Hospital for admission if there are no beds available in Wales, would AMHPs be working to two different sets of criteria for admission?*

While agreeing with the proposal, one respondent (Adferaid MHB023) queried whether **Wales has the power** to amend the detention criteria:

> *Yes, we agree with this, although we question whether Welsh Government has the devolved power to amend legislation relating to the criteria for detention.*

5. Proposal to change the criteria so there must be reasonable prospect of therapeutic benefit to the patient

Again, there was **broad agreement with the principle** but the view that 'therapeutic benefit' **needs to be defined**. A key message in responses was that **clear guidance** will be needed and should allow for the use of clinical expertise/professional judgement and multi-disciplinary input.

An individual with lived experience of the mental health system (MHB002) told us:

> *There should be clear guidance as to what 'reasonable' means in this regard, and this should relate to the objective evidence that exists for benefit from Psychiatric intervention in a setting of detainment. [...] At present detainment is used for the prevention of risk to society primarily and there is little evidence of benefit to the person.*

Public Health Wales (MHB026) said:

> *Clarity will be required on what constitutes therapeutic benefit and who will make the determination of probable benefit, including consideration of views from individuals themselves, Nominated Persons or carers and relatives.*

Adult mental health services: therapies at Cardiff and Vale University Health Board (MHB020) told us:

> *it is important that all professions "therapeutic offer" is valued, if it is of benefit to the individual. The AHP [allied health professional] workforce is large, although currently makes up a small proportion of the workforce; exploring all aspects of an individuals needs, for example participation in activities, building routine, undertaking roles, mobilising and being physically active, feeding self. It is important that all therapies are considered as part of the delivery of care*

The Royal Pharmaceutical Society (MHB012) said:

> *We would also encourage that determination of this should, where possible, be considered by a multi professional team involved in the individual's care and support in order bring different expertise into the equation.*

Some respondents (see for example MHB021, MHB026, MHB028) highlighted the importance of clinicians and staff having an empathetic and **trauma-informed** approach, referencing the Trauma-informed Wales framework.

It was also noted that there may be cases where there **may not be realistic prospect of therapeutic benefit**, or difficulty evidencing this, but **detention may still be necessary**/the best course of action if a person is a risk to themselves or others.

Cardiff and Vale University Health Board (MHB016) for example said:

> *In relation to Public Protection, Forensic detentions and the management of public safety may be exclusions that may safeguard the benefit of the public but not necessarily be of 'therapeutic' benefit to the patient. On occasion detention under the Mental Health Act may be for treatment where the therapeutic benefit is uncertain, unclear, or measured in years may be difficult to define under this definition.*

The Children's Commissioner (MHB011) told us:

> *My office are aware of occasions, though, where children and young people are detained as they pose a risk to themselves or others, but because they do not have a diagnosable mental health condition, and alternative provision may not be available, they may not have a realistic prospect of therapeutic benefit.*

Similar to a point made in relation to changing the detention criteria, a small number of respondents highlighted a potential risk that a decision regarding lack of therapeutic benefit could be made to **avoid placing more demands on overstretched services**, rather than being made for the benefit of the individual.

Swansea Council (MHB004) told us:

> *There has generally been the principle that admission to hospital is for treatment and to prevent deterioration in someone's condition and because of risk to public or patient. However, without resource to provide the best services, cash strapped Health Boards may take the opportunity to suggest that treatment is not available to prevent admission to already overcrowded wards.*

Again, the **cross-border implications** of this proposal were highlighted.

Hywel Dda University Health Board (MHB005) told us:

> *As the MHA [Mental Health Act] applies to both England and Wales this would need to be changed in both Countries as the MHRT [Mental Health Review Tribunal] criteria is the same for both.*

Some **wording changes** were suggested. It was suggested that 'reasonable prospect' should be changed to 'clear and convincing evidence' (MHB017 Mind Cymru). Also that the wording should say 'should' or 'must unless there are exceptional circumstances' (MHB019 WLGA).

6. Proposal to introduce remote (virtual) assessment under 'specific provisions' relating to Second Opinion Appointed Doctors (SOADs), and Independent Mental Health Advocates (IMHA)

There were mixed views here, but a key point was the **need for more detail** about this proposal, including the 'specific provisions'. There was also a common view that remote assessments, if introduced, should be an **informed choice** on the part of the individual. Individuals should still have the **right to a face to face assessment**.

Supporting the proposal, an individual responding in a professional capacity (MHB003) told us:

> *I do agree as there are many factors that can deny a patient access to services including, geography, transport and anxiety. Virtual assessments could address some of these factors. This would also allow for a greater access to Welsh language provision.*

DHCW (MHB007) said:

> *This promotes delivering care in a less restrictive setting. Ensures care is clinically safe, with due privacy, confidentiality respected and protected. In addition, this presents an opportunity for digital tools to be embedded to enable these remote assessments and provide further benefits such as recording and share of key data.*

A mental health professional (MHB001) told us:

> *I would agree that this would certainly speed up the process of gaining a second opinion for a patient, especially for patients on a CTO [Community Treatment Order] or those in need of ECT [electroconvulsive therapy] treatment.*

A small number explicitly **disagreed** with the proposal, while others called for more **clarity and detail** before forming an opinion.

Swansea Council for example said:

> *Not under any circumstances. It is of vital importance that anyone assessing someone for initial detention and continued detention speak to the individual personally. It is the principle of examining an individual face to face that I believe should be upheld. This does not mean via a screen.*

Mind Cymru (MHB017) said:

> *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?

The Law Society (MHB32), among others, suggested that:

The reference to 'specific provisions' is unclear and requires further explanation.

A number of respondents highlighted the value of face to face assessment vs the limitations of remote assessment.

WAST (MHB015) for example told us:

Virtual assessments are undoubtedly more efficient; however, from experience they may not provide the assessor with all of the knowledge they require to complete the assessment – the SOAD may rely on some of the initial doctor's opinion to complete their assessment which is not in keeping with the reasoning behind having a SOAD.

Cardiff and Vale University Health Board (MHB016) said:

The opinion of professionals was that face to face assessment and contact is of greater therapeutic impact and promotes closer engagement and rapport than a virtual appointment.

The Welsh NHS Confederation (MHB028) told us:

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.

A common view was that remote assessment could be an option as long as this was the individual's informed choice rather than out of convenience to the SOAD/IMHA. Additionally, it must be ensured that those without access to digital technology are not disadvantaged, for example by having to wait longer for assessments.

Public Health Wales (MHB026) told us:

> *Maintaining the principle of 'Choice and Autonomy' will be important in respect to individual preferences for remote or in-person assessments.*

Barnardo's Cymru (MHB024) said:

> *It is our view that remote assessment can be a welcome addition, when it is offered as one of a number of options for patients which allows for a choice between remote assessment, in-person, and the opportunity for there to be a mixture of both over the course of a period of treatment.*

Age Cymru (MHB014) cautioned:

> *However, the introduction of remote assessment must not disadvantage individuals who are digitally excluded. This is a particular issue for older people: one in three people over 75 in Wales have no access to the internet, and another one in three over 60 do not use a smartphone. Those older people who live in rural areas or who live with a disability or long-term health condition are especially likely to be digitally excluded. It is important that those who cannot or choose not to access the internet are not disadvantaged in any way when seeking mental health assessments.*

Two responses suggested that the SOAD role is there to **protect the system** (i.e. to ensure the first opinion isn't vulnerable to challenge) rather than to benefit the individual (see MHB002 and MHB010).

An individual responding in both a professional and personal capacity (MHB010) told us:

> *Our recent personal experiences of Mental Health Assessments have shown that even when the SOAD is present in person, their role as an objective opinion and decision-maker has not been as robust as it should be. If this role were to become virtual, I believe it would be little more than a box-ticking exercise without the careful considerations vital for robust decisions. It is essential that the SOAD sees and examines in person to ensure they have all the information needed for a sound diagnosis and decision about detention to be made.*

7. 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

There was **widespread agreement** with this proposal and a strong view that it would **support children's rights**. The main caveats/concerns raised by respondents in relation to this proposal included the need to consider the **capacity of CAMHS and resource implications** of a potential increase in referrals, and how children and young people would be supported to **understand and access this right**. The issue of Gillick competence was also raised.

The Children's Commissioner (MHB011) told us:

> *I am pleased to see the proposed amendment to the Mental Health Measure, which would remove the age limit on requesting a reassessment, as this would further a child's right to have their voice heard. This right includes a child's views on all aspects of healthcare. Under article 25 of the UN Convention, children also have a specific right to a regular review of their treatment, and wider care, if they have been placed away from home for the purposes or care or protection. This proposal, therefore, would enhance access to these rights for children affected; empowering children in line with the Convention, to which Welsh Government Ministers must pay due regard.*

The WLGA (MHB019) said:

> *we are aware that there are significant delays in access to child mental health provision and so are concerned about the capacity in the system to be able to undertake any additional re-assessments. This could lead to an increase in the waiting lists, with delays in appropriate medication or therapeutic interventions.*

Public Health Wales (MHB026) similarly highlighted that:

> *Capacity and resourcing implications for already stretched services will need careful consideration for effective implementation.*

Barnardo's Cymru (MHB024) said:

> *we would welcome further clarity on how a young person would be supported to make and understand this choice and the outcomes. [...] It would also be important to understand to the extent to which young people understand their rights currently and how this new right would be communicated to young people.*

The Law Society (MHB032) highlighted that:

> *for this to improve patient access to mental health services there needs to be greater awareness of the right to re-assessment. A 2019 review of Community Mental Health Teams (CMHTs) found that less than half (43%) of previous patients knew they could re-refer themselves to a CMHT if they were relapsing.*

In relation to Gillick competence, the WLGA (MHB019) told us:

> *We would be keen for there to be discussion and guidance for how this would be applied to those under the age of 18, especially in regard to the Gillick competency which is often used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.*

[Children under the age of 16 can consent to their own treatment if they're believed to have sufficient maturity and intelligence to fully understand what their treatment involves and its implications. This is known as being Gillick competent.]

8. Proposal to amend the Measure to extend the ability to request a re-assessment to people specified by the patient

There was also **broad agreement** with this proposal, with some responses highlighting that an individual who is unwell may not be in a state of mind to refer themselves. A number of respondents called for **more clarity** about what 'people specified by the patient' means, and how this relates to the **role of Nominated Person**.

RCGP Cymru Wales (MHB027) for example highlighted that:

> *patients may not have insight at the time to realise that a re-assessment is in their interests when they are acutely unwell.*

The Royal College of Paediatrics and Child Health (RCPCH) (MHB029) told us:

> *the Bill should clarify what is meant by extending the provision 'to people specified by the patient'. This section should expand on the type of people (parents, siblings, carers for example) that are able to request a re-assessment and in what situation this should occur. The Bill should clarify if this will take on the form of a Nominated person which is discussed in Section 8 of the Bill.*
>
> *The Bill also needs to include the role of the trusted adult and how this would interact wit the ability to request a re-assessment.*

The WLGA (MHB019) suggested that:

> *there should be consideration on extending the role of the nominated person or persons to automatically include this option. It would reduce any confusion and mean there is consistency of who can make the request especially where the patient themselves is incapacitated. We would also suggest there would need to be consideration around the action to take when the patient and nominated person disagree in this regard and how mental capacity for decision making would be made and recorded.*

Again, respondents highlighted the need for robust **safeguards to prevent exploitation** and/or coercion.

Age Cymru (MHB014) for example told us:

> *As per our response to Question 3, there must be robust safeguards in place to prevent cases of abuse during the process of nominating someone to act as a representative to the patient.*

An individual responding in a professional capacity (MHB003) said:

> *In the correct circumstance I would agree as patients do not always have the capacity to manage their own care. I would be wary of potential exploitation and would want to see robust regulation around Advocacy and control.*

The Welsh NHS Confederation (MHB028) called for "very clear guidance" on the management of this proposal.

9. The impact of the proposals across different population groups

Responses highlighted the **disproportionate, negative impacts of current legislation** (the Mental Health Act) on some groups (e.g. racialised communities and people with learning disabilities). A number of respondents suggested that the proposals could **help address inequalities in access to/experience of services** for a range of groups including for example children, older people, ethnic minorities, neurodivergent people, people with learning disabilities, and transient population groups (who, for example, could benefit from the change to Nominated Person).

The Law Society (MHB032) for example told us:

> *The Independent Review found that research consistently shows higher levels of detention in Black African and Caribbean people. Many of the proposals in this consultation document will help ensure the Mental Health Act is used in the least restrictive way possible and that all people who are detained against their will have their views and choices respected.*

The British Association for Counselling and Psychotherapy (MHB013) said:

> *Enshrining in legislation the principles of greater choice and autonomy, Therapeutic Benefit and the need to ensure a person centred approach to care will have an increased benefit particularly on marginalised groups and communities.*

Age Cymru (MHB014) told us:

> *These proposals have the potential to greatly improve older people's access to and experience of mental health care. In particular, they offer the possibility of increasing the agency of older people through mental health care pathways, as well as ensuring that any care offered is more appropriate to their personal needs. Furthermore, these proposals have the potential to change the culture around older people accessing mental health support.*

Some responses highlighted the risk of a negative impact of the proposed legislation on some groups e.g. children/adults at risk of abuse, and the need for safeguards to be in place.

The WLGA (MHB019) cautioned:

> *as it currently stands it could have a detrimental impact on children, adults at risk, victims of hate crime, harassment and domestic abuse where there is a mental health concern with limitations in the definition on if this relates to only physical harm, whilst criminal justice legislation now includes other forms of harm (see our answer to question 4), and if safeguarding is not included in the considerations.*

Cardiff and Vale University Health Board (MHB016) said:

> *Mental Health law has evolved since the Mental Health Act 1983 and the clinical teams raised concern about the impact of these changes for groups such as forensic patients, patients subject to Community Treatment Orders, and those patients with diagnostic uncertainty where therapeutic benefit may be uncertain.*

The lack of existing specialist provision for Deaf people was highlighted.

The All Wales Deaf Mental Health and Well-Being Group (MHB009) told us:

> *Potentially any changes that make mental health services in Wales more equitable and more accessible are very welcome. We are aware of the impact of the current lack of service provision for Deaf people in Wales, particularly those requiring in-patient hospital provision and the need for patients having to travel to England for treatment. We wish to highlight the lack of Deaf*

> *awareness training that health and care staff have, and also the lack of specialist Deaf mental health provision.*

Some responses also called for a full **equality impact assessment**, and further engagement with a **range of demographic groups**/representing organisations (including for example those with protected characteristics, those with previous experience of mental health services, migrant populations, people in rural areas).

The Welsh NHS Confederation (MHB028) said:

> *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.*

10. The impact of the proposals on children's rights

There was broad, general agreement that the proposals **strengthen the rights and voice of children**. Some respondents highlighted the need for **engagement with children and young people** and the professionals who support them, and further consideration of the impact of the proposals on children's rights.

DHCW (MHB007) for example said the proposed legislation:

> *Strengthens the voice and rights of children. Helps reduce the stigma of mental health and encourages children to be involved in their care and treatment plans. Hopefully treating mental health in children and young people more effectively, will help prevent mental health crisis later in their life.*

Barnardo's Cymru (MHB024) called for children's versions of legislation and consultation documents etc. to be produced:

> *it is not yet clear how this new legislation, including this proposal will be shared with children and young people. We would recommend a children's version of the proposed legislation, and as this Bill seeks to progress through the relevant mechanisms, we would like to see further children's versions of*

> *consultations, scoping work including outcomes and amendments to the proposed legislation.*

The Children's Commissioner (MHB011) called for a comprehensive Children's Rights Impact Assessment (CRIA) to be undertaken.

A small number of respondents (see MHB028, MHB031, MHB032) queried how the proposals interact with the law relating to **parental responsibility**.

The Welsh NHS Confederation (MHB028) for example said:

> *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.*

11. Barriers to implementation and effectiveness

A key theme raised in responses was the need for greater consideration of the **cross-border implications** of different rights/legislation applying in Wales and England. This was particularly raised in relation to the proposals which would amend the Mental Health Act 1983, with a number of responses suggested that a UK-wide approach would be preferable.

Adult mental health services: therapies at Cardiff and Vale University Health Board (MHB020) told us:

> *A barrier to some of the potential changes means that legislation will not align with that in England and could cause problems with out of area placements and transfers of care.*

Cardiff Council (MHB031) similarly said:

> *One concern is on the grounds that it may cause significant problems when people from Wales are admitted to hospital in England or vice versa. Cross-border arrangements will need to be made to detail which admission criteria is applied, the English or Welsh.*

Hywel Dda University Health Board (MHB005) told us:

> *Under current legislation (MHA,1983) the Nearest relative has the right of appeal to the MHRTfW [Mental Health Review Tribunal for Wales], for those Welsh patients who are detained in England, how would that apply if there are plans to transfer them across border under Section 19. Unsure how this would work in practice.*

Age Cymru (MHB014) said:

> *We would also like to see greater clarity around how this proposed bill interacts with the UK Draft Mental Health Bill 2022, with which it shares many similar features. As work continues on this proposed legislation, it would be useful to examine how closely it aligns with the UK bill and how any legislative crossovers between the two are expected to be tackled in future.*

Resource implications and affordability was another clear theme. A number of respondents suggested the legislation will be ineffective unless mental health services are adequately resourced. The proposals could also lead to **additional demands on community services** (including health but also social care, housing etc.) and there may be need for increased resources in those areas.

The WLGA (MHB019) for example told us:

> *we think it may lead to additional burdens on Councils, Primary Care, and Housing providers which will have to be taken into consideration and appropriate resources identified.*

Age Cymru (MHB014) told us:

> *a change to the legislation around mental health could only be of limited value if mental health care itself is not adequately resourced.*

The Welsh NHS Confederation (MHB028) pointed to “already stretched services” and suggested that capacity and resourcing implications will need careful consideration in order for the proposals to be effectively implemented.

Some respondents suggested that **wider, cultural change** will be needed in order to realise the ambitions of the legislation.

An individual with lived experience of **the mental health system** (MHB002) told us:

> *There is a serious likelihood that the wording in the proposed legislation will not result in any fundamental change in the way these services are delivered. The beliefs of staff who have been trained and inculcated in the existing culture will be difficult to change.*

Platfform (MHB021) said that:

> *One point we need to clarify is that choice and autonomy must be defined as "free and informed choice and autonomy". This requires a major shift of culture in our healthcare system, move away from an outdated and narrow biomedical view and commitment to sharing knowledge about the efficacy, limitations and side-effects of widespread mental health interventions (e.g, work must be undertaken to challenge the incorrect, oversimplified "chemical imbalance" theory that is still held as fact by c.80%5 of the public).*

Two responses questioned whether some provisions (particular reference was made to detention criteria) are **outside competence** and likely to lead to **legal challenge** (see **MHB023 Adferiad, MHB031 Cardiff Council**).

12. Strengthening the legislation/additional issues

Two respondents suggested that consideration should be given to **amending Part 1 of the Measure to expand the list of professionals able to undertake assessments** in Local Primary Mental health Support Services (LPMHSS).

The British Association for Counselling and Psychotherapy (MHB013) told us:

> *An important area outside the competence of this legislation, as currently drafted, is the need to review Part 1 of the Mental Health Measure which stipulates which professionals can undertake Local Primary Mental Health Support Service (LPMHSS) assessments. [...] The 2017 Duty to Review (the Measure) Report recommended amending the legislation to expand the list of health professionals that can undertake assessments to improve access and address some of the barriers to assessment. This has yet to be undertaken by Welsh Government.*

The British Psychological Society (MHB025) similarly said:

> *With the creation of professions in mental health services both recently and possibly in the future, there is opportunity for the Bill to expand the Measure to widen the list of professions able to provide mental health assessments in Local Primary Care Mental Health Support Services (LPCMHSS), and to those who are able to become Care Coordinators.*

Some responses said that specific consideration should be given to **strengthening requirements regarding the use of restrictive practices**, suggesting that the proposals have little detail about reducing/eliminating use of restrictive practice apart from a very general principle.

Adferiad (MHB023) told us:

> *The proposed Bill has little to say on the detail of reducing or eliminating the use of coercion and restrictive practices apart from applying the very general principle, 'the exercise of any power under the Act must be done in the least restrictive and least invasive manner consistent with the purpose and principles of the Act'. Third sector organisations have been calling on the Welsh Government to legislate to end the use of face down restraint in Wales. We want all Health Boards in Wales to properly record any instance where a patient is restrained.*

Mind Cymru (MHB017) said:

> *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.*

Platfform (MHB021) also told us:

> *We want to reiterate our support for these changes – but to include the caveat that these changes must be the start of a journey across Wales to tackle the widespread use of restrictive practice.*

A further point was the need to ensure the bill **aligns with existing legislation and strategy/frameworks** (reference was made for example to the Mental Health (Wales) Measure, Mental Capacity Act, the Welsh Government's new draft mental health strategy, and trauma informed framework).

The WLGA (MHB019) said:

> *We are also concerned that both this Bill and the Draft Mental Health and Wellbeing Strategy 2024-2034 are being consulted on at the same time which could cause confusion if changes are not reflected across them both.*

Adult mental health services: therapies at Cardiff and Vale University Health Board (MHB020) highlighted the following:

> *Already mentioned throughout, but ensuring that existing strategies e.g. MH strategy, rehab model are weaved into any new standards to ensure consistency, transparency, joint ways of working and shared ways of working.*

Annex A: List of respondents

MHB001 – Individual

MHB002 - Individual

MHB003 - Individual

MHB004 - Swansea Council

MHB005 - Hywel Dda University Health Board

MHB006 - Individual

MHB007 – Digital Health and Care Wales

MHB008 - Individual

MHB009 - All Wales Deaf Mental Health and Well-Being Group

MHB010 - Individual

MHB011 - Children's Commissioner

MHB012 - Royal Pharmaceutical Society

MHB013 - British Association for Counselling and Psychotherapy

MHB014 - Age Cymru

MHB015 - Welsh Ambulance Services University NHS Trust

MHB016 - Cardiff and Vale University Health Board

MHB017 - Mind Cymru

MHB018 - All Wales People First

MHB019 – Welsh Local Government Association

MHB020 - Adult mental health services: therapies, Cardiff and Vale University Health Board

MHB021 - Platfform

MHB022 - Public Services Ombudsman for Wales

MHB023 - Adferiad

MHB024 - Barnardo's Cymru

MHB025 - British Psychological Society

MHB026 - Public Health Wales

MHB027 - Royal College of General Practitioners Cymru Wales

MHB028 - Welsh NHS Confederation

MHB029 - Royal College of Paediatrics and Child Health (Wales)

MHB030 - Equality and Human Rights Commission

MHB031 - Cardiff Council

MHB032 - The Law Society