WLGA Response

24 January 2025

Legislative Consent Memorandum for the Mental Health Bill

Introduction

To inform the Health and Social Care Committee's scrutiny of the Legislative Consent Memorandum ("the LCM") on the Mental Health Bill ("the Bill"), the WLGA were contacted by letter to provide our views on the matters listed in their letter under provided headings and questions.

This response (from page two) provides a written response to the matters listed and to be submitted no later than 24 January 2025.

Introduction to the WLGA

Welsh Local Government Association: We are the Welsh Local Government Association (WLGA); a politically led cross-party organisation that seeks to give local government a strong voice at a national level. We represent the interests of local government and promote local democracy in Wales.

The 22 councils in Wales are our members and the three fire and rescue authorities and three national park authorities are associate members.

We believe that the ideas that change people's lives, happen locally.

Communities are at their best when they feel connected to their council through local democracy. By championing, facilitating, and achieving these connections, we can build a vibrant local democracy that allows communities to thrive.

Our ultimate goal is to promote, protect, support and develop democratic local government and the interests of councils in Wales.

We'll achieve our vision by

- Promoting the role and prominence of councillors and council leaders
- Ensuring maximum local discretion in legislation or statutory guidance
- Championing and securing long-term and sustainable funding for councils
- Promoting sector-led improvement
- Encouraging a vibrant local democracy, promoting greater diversity
- Supporting councils to effectively manage their workforce.

WLGA response

Overall views

1. Your overall views on the policy objectives of the Bill to:

a. modernise mental health legislation to give patients greater choice, autonomy, enhanced rights and support; and ensure everyone is treated with dignity and respect throughout treatment; and

The Bill aims to deliver on recommendations from The Independent Review of the Mental Health Act 1983 (2018) which highlighted that service users and stakeholders consistently found the current model of family and carer involvement outdated and insufficient. It also aims to bring it more in line with a social model of care rather than the medical model which has dominated mental health.

The Mental Health Act 1983 was founded over 40 years ago, with a different backdrop and environment. The closure of mental hospitals following the reports of institutionalised abuse was still in progress and the recognition of unpaid carers was still in its infancy only being introduced in 1976, and the focus on community care for mental health patients introduced in legislation seven years later.

The move to coproduction, choice and patients rights have all grown since the Act was first introduced. These were areas also identified in the 2018 report. There have been dramatic changes since the 2018 report, including a global pandemic and cost of living crisis. Therefore, it follows that by bringing in these elements into the legislation that the Bill will modernise the mental health legislation and bring it closer to more recent legislation for health and social care.

There does however continue to be a heavy focus on hospital-based services and on secondary crisis health care. Placing a greater focus on early intervention and prevention or a social model of care could reduce demand on hospitals and change the focus to local support in the community, including through primary care, social care and other council delivered services. This requires a wider discussion around the movement of funding into other parts of the health and social care system and beyond.

The introduction of Nominated Persons in place of Nearest Relative responds to the changing demographics of the population with more people living away from family members and having ‘chosen family’ made up of friends and others that are not related. It allows the autonomy to decide that a partner, someone they are not married to, can make mental health choices ahead of a parent that they are estranged from or an ex where a divorce is not yet finalised. There are safeguarding concerns around how this will be safely implemented but from an equalities perspective it has been an issue that has needed to be addressed for a number of years.

Just as people should not have been put in mental hospitals for non-mental health conditions, they should not be accessing mental-health hospital provision when there are better alternatives available. Treatment can be provided in the community, through a more

integrated health and social care approach. This change has the potential to further enable delivery of social care outcomes that are agreed with people rather than delivering outputs.

Whilst we agree with the principle of those with severe mental-health crisis accessing hospital-based care and not being held in prison or police cells, due to the numbers that could be involved and the potential unintended consequences of the introduction of a statutory 28-days for them to be given a hospital bed and moved from the prison estate this requires a transition period. This would help to limit any negative impact on the population outside of the criminal justice system and a revision of the funding that has been included in the Explanatory Notes to date which is unlikely to be sufficient to deliver a reduction in the need for hospital-based services as currently set out.

Social Care, housing and education are important partners alongside health in delivering early intervention and prevention as well as care and support and additional learning needs support. However, the legislation does not currently reflect this, with social care and housing being understated, and no mention of education at all. As a result, there is potential for any consequential funding being lower than the cost to deliver the legislation and a risk that the responsibility will sit with councils to fund from budgets that are already stretched to their limits.

b. introduce measures to improve the care and support of people with a learning disability and autistic people, reducing reliance on hospital-based care.

Overall, we believe that the changes being brought in by the Bill and the distinction between Autism, Learning disability and Psychiatric episodes or illness is particularly useful and should help to improve care and support for people, and potentially reduce the stigma that can come with a mental health diagnosis.

Whilst it may reduce reliance on hospital-based care there are concerns that conversely there may be increased demands placed other parts of the health service and hospital-based care away from Mental Health as a result. A number of the People First charities across Wales have raised awareness around the lack of annual health checks for those with a learning disability. These health checks are designed to catch issues early on so that more early intervention action can be taken, but without these being available in the volumes needed due to the capacity for GPs and the fact that the health check can take the time of eight regular patient timeslots adds to the pressures. Whilst accessing mental health beds may not have always been appropriate other health issues were occasionally identified early and treated so preventing possible future hospital admissions in other areas such as cardiovascular.

The number of people being diagnosed with autism continues to rise as awareness increases, with health boards seeing substantial rises in referrals to neurodivergent services. In Betsi Cadwaladr University Health Board there has been a doubling of reported referrals each month from 200 to 400. This increase may result in increased reliance on hospital-based care where autism is a comorbidity, this may be with psychiatric conditions requiring

mental health services or it could be in other disciplines and conditions as people with diagnosis continue to age.

The health services supporting those with autism and other neurodivergent conditions are under pressure due to the increase in demand, but this also has an impact on associated services such as social care with increased care and support needs, education with increased additional learning needs and support and the challenge alongside large class sizes and challenging school budgets. This continuing increase means that the ongoing impact on all services involved, including mental health and other health-based care is not yet fully understood and predictable for planning purposes.

The Bill as proposed should reduce the number of hospital-based beds inappropriately taken, but beyond that there is limited evidence that there will be any decrease in demand for hospital beds.

2. *What barriers do you think currently exist in accessing mental health services in Wales, and does the Bill address these adequately?*

The main barrier currently is the lack of capacity within mental health services, especially for children and young people, which leaves people waiting longer, for the help and treatment they need. It is unclear how the Bill will begin to address this in Wales. Additional finance that is ring-fenced to deliver the requirements in the Bill would be helpful and allow councils to continue to deliver and develop services that are working on higher complexities. Funding needs to flow through the whole of the system especially into community provision, as reductions in secondary health settings are likely to only be achieved by primary and community health working in an integrated manner with council provision in social care, housing and education.

There are a number of other barriers, including: funding, including short term grants; workforce skills, recruitment and retention; complicated partnership landscapes involving devolved and reserved agencies and crossover between Public Service Boards (involve criminal justice but not health) and Regional Partnership Boards (involve health but not criminal justice); and inadequate mental health services meaning multi agency approaches are not always possible despite improving relationships between individuals due to ongoing capacity and resource issues. The Bill does not appear to address any of these.

The Bill does focus on getting people into the right service and support which is welcome. However this in itself may lead to a gap that is not yet known of the need for more specialist services that are specifically for people with autism or learning disabilities to enable them to manage their own health and not require different or more complex mental health needs later because early intervention was missed due to the new policy meaning a low level mental health condition was misdiagnosed as being part of their autism or learning disability diagnosis.

Impact on areas of devolved competence

3. Do you support the principle of Westminster legislating in areas that are devolved to the Welsh Government?

The WLGA believes that services are best provided within a democratic framework of local accountability and that the people who use public services should have as much of a say in the way they are organised, managed and funded as possible.

Within this context however, the WLGA supports the principle of Westminster legislating in areas that are devolved to the Welsh Government, as long as the Senedd Cymru consents to this via the Legislative Consent Memorandum (LCM) process. The WLGA supports devolution and believes that decisions should be taken as close to our residents as possible. In those cases where a UK-wide framework is seen as being required for legislation to be implemented effectively, the WLGA recognises the value of the Welsh and UK Parliaments and governments negotiating in order to legislate consensually to make the appropriate modifications to the powers of the Welsh Ministers. Where the Senedd Cymru does not consent to UK legislation during the LCM process, we believe that UK Ministers should respect this and work constructively with the Welsh Government of the day to amend any legislation accordingly.

We are supportive of the Sewel Convention principle and believe that the lack of consistency in its application maybe impacting negatively on the democratic processes that are in place. There should be time built in for scrutiny by the Senedd Committee's as is the case with the Mental Health Bill and the WLGA welcomes this opportunity to input to that scrutiny through the request received on the 13 January 2025.

In regard to the current LCM and Supplementary LCM we agree with the Minister's appraisal of which clauses should be included within the LCM, we think that some of the clauses involve both reserved and devolved matters (such as the Prison estate and Health) and in these instances would expect them to be included within the LCM. We also think that where additional powers are asked for Westminster Secretaries and Ministers to carry out additional legislative activity that this should always either be matched with a requirement to return to the Senedd for consent or for Welsh Ministers to be able to legislate alongside and for Wales only on devolved matters impacted by the Westminster legislation.

We would also like to lend our support to the current requirement that the code of practice that is included within the legislation and which will be specific to Wales, agreed by the Welsh Government should remain a devolved matter to prevent confusion or any conflicts between changes brought through Westminster legislation and Wales specific legislation, especially the Social Services and Wellbeing (Wales) Act 2014, the Wellbeing of Future Generations (Wales) Act 2015 and the Health and Public Health legislation alongside the different Welsh landscape.

Alignment with policy priorities

4. Do you think the provisions of the Mental Health Bill align with the Welsh Government's Mental Health strategy and broader policy priorities?

The last Mental Health Strategy ran until 2022 and the new 2024-2034 strategy remains to be published. However, based on the information included in the draft strategies for Mental Health and for Suicide and Self-Harm Prevention that were consulted on in June 2024 it would appear there is alignment. Especially in areas of consent, Deprivation of Liberty and the provision of more care and support closer to home and in the community.

5. Are there specific Welsh priorities or policies that should be better reflected in the Bill?

The Social Services and Wellbeing (Wales) Act 2014, the Wellbeing of Generations (Wales) Act 2015, the Public Health (Wales) Act 2017 amongst others require collaboration, engagement and coproduction. There does not appear to be much inclusion of these within the proposed legislation, which also provides the care and support planning process for England. It may be helpful to make reference and direct to the legislation and guidance for care and support planning in Wales.

There may be variances in regard to a strength-based approach, being outcomes rather than output focused and how Trauma Informed Practice responses to Adverse Childhood Experiences may interact and be impacted by changes in the Bill. The trauma inflicted by a parent with a mental health condition on a child may not surface for a number of years, and perhaps not until they are in adulthood themselves. Therefore, if we are to truly change the outcome of ACEs on adult provision, early intervention and support starts when they are a child, and continues to be available, it should not wait until they hit their first crisis as an adult.

Cross-border considerations

6. How will the Bill address the movement of patients across the Wales-England border, ensuring smooth collaboration between services?

Having the same approach across England and Wales for both the prison system (reserved) and for health (devolved) appears to be sensible. Mental Health patients often need to be placed outside of a local area due to the demand for beds and around one third of all those held in the five Welsh prisons are from England, whilst all 16 and under and women from Wales need to be placed in English prisons as there are no facilities for them currently within Wales. Having one set of processes should make it easier to navigate for individuals and their families as well as for prison, health and council staff.

Application of the Mental Health Act 1983: autism and learning disability

7. How will the Bill's provisions integrate with Welsh Government's efforts to reduce mental health-related hospital admissions? Specifically, your views on proposals to amend the Mental Health Act 1983 so that people with a learning disability and/or autism cannot be detained for compulsory treatment unless they have a "psychiatric disorder".

The change to allowing an individual to only be detained for compulsory treatment for a psychiatric disorder is a positive one and builds on the approach of providing the right care, for the right person in the right place. It should reduce metal health related hospital admissions that were not always appropriate, but it may not reduce mental health-related hospital admissions as there is an increase in demand for mental health services from the community, an increase of severity following the pandemic and its impacts, and the potential increase in hospital transfers from prison into mental health beds.

The need to invest in community services including primary care, as well as councils needs to come first and then the demand and complexities that are being presented to council colleagues in areas such as social care, housing, education and public protection may mean that it is a number of years before the number of admissions is reduced. It may be that the number of admissions increases because of the prevention activities undertaken. There may be an increase in the speed of discharge from the time of entry which would open up the bed more frequently to provide more short-term health treatment support in hospital alongside the longer term treatments that will still be needed for patients in the most crisis.

The implementation of Right Care, Right Person may also increase demand on health beds when crisis occurs due to the change in role of the police and the lack of funding to develop new or additional community-based capacity.

Consultation with the community clinician

8. Your views on proposals to introduce a new requirement for hospital clinicians to collaborate with a second professional from a community service when making decisions regarding the use and operation of community treatment orders ("CTO").

We agree in principle providing there are the appropriately qualified professionals within community services to be consulted with. There may be an opportunity to expand this to bring in engagement with social care and housing, so that whilst the decision may sit with the hospital and community clinician those providing social care and housing are part of the engagement. This would link in with the requirements for council social care teams to be part of the hospital discharge process making for a more seamless transition.

Nominated person

9. Your views on:

a. the proposed introduction of a "nominated person" role to replace the nearest relative in decision-making;

We agree in principle especially with the positive implications this will have on those who are estranged or have strained relationships with their families. The Census data shows a continuing change in living arrangements, so the change from Nearest Relative to

Nominated Person would appear appropriate and protect individuals from having their wishes overturned by family members who they have no contact with.

It would be beneficial to have two identified Nominated Persons in case the first is unavailable. Whilst this would not have the same level of progression down the eight different categories under Nearest Relative it would provide some resilience against unplanned absences, accidents or holidays if only one person is nominated.

There will be a need to consider how the Nominated Person provisions will work through more detailed guidance. For example, how will this be agreed and by whom? How will this crossover with any unpaid carer(s) and the responsibilities they provide in care and support for the individual? Will there be a need for a list to be maintained and how would this be monitored? How will details of the Nominated Person be shared and accessed at times of crisis by health, social services or other professionals? The legislation as currently laid out places the responsibility on health or Advanced Mental Health Professionals rather than on the wider social care and social workers who may be involved outside of crisis. This seems to work against the increased integrated work between health and social services and could form part of the social care plan which stays with the individual and can be updated as needed.

Consideration will also need to be given to whether the displacement of Nearest relative provision would remain but be displacement of nominated person and if so whether the grounds to displace would need to be updated. There will also need to be consideration on how a nominated person will work alongside a Lasting Power of Attorney (LPA) for health and welfare if the LPA and nominated person are different and hold differing opinions.

There does not appear to be provision for a second Nominated Person to be in place for if the Nominated Person is unavailable due to illness, accident, holiday or other life events such as pregnancy or bereavement. This could leave a gap which does not exist in the current system involving nearest relatives which can be worked down. There could be different levels set as can be applied when a Power of Attorney has been sought or a set order as often applies with emergency contacts in settings such as schools.

The language that refers to needing to consult a person if they “appears” to have nominated a person is ambiguous and could lead to people being excluded who should be included or included who should not be. There needs to be a clear process of consent and confirmation to protect an individual from exploitation or from having their views ignored and misrepresented because a non-nominated person is accidentally given nominated person rights.

b. the extent to which this proposed reform is consistent with the Welsh Government's vision for a rights-based approach to mental health care?

The proposed reform appears consistent with the Welsh Government's vision for a rights-based approach to mental health care, and to more health and care being provided closer to home including in communities.

There does appear to be a gap in the current legislation which does not make reference to unpaid carers, who in Wales should be part of any discharge from hospital process. The current legislation may put the rights of the person requiring mental health care ahead of the rights of the unpaid carer. It is important that an individual, nominated persons and clinicians are not able to go against the rights of an unpaid carer when discharging into the community. This is especially important where the hospital admission followed particularly traumatic events for the unpaid carer(s), including young carers, which may have involved violence or witnessing self-harm which can be distressing.

Deprivation of liberty

10. How does the Bill address the use of compulsion and deprivation of liberty in mental health care (e.g. to shorten the period etc), and does it respect Wales's legislative competence in these areas?

The Mental Health Bill as it currently stands may fall short of what is covered in Wales, as it does not appear that the legislation is expanding the definition of where Deprivation of Liberty (DoLS) applies beyond care homes and hospital. Whereas according to Social Care Wales it can also apply in a persons own home, as well as a care home or hospital, which seems to be implied in paragraph 267 of the Explanatory Notes. We would ask that this is correctly reflected in the legislation going forward.

The reduced length of time from six months to three months demonstrates the need to be sure that the treatment or services are correct for an individual in a timely manner and therefore we understand this applies to comply with the arrangements for Wales, as set out in the Social Services and Wellbeing (Wales) Act 2014.

The change of the burden of proof from the individual to prove they no longer need a guardianship order to being on a local authority to prove that they do, will increase pressures on already stretched resources. This transition will need to be managed carefully and with appropriate training of council and court staff otherwise there is a risk that a guardianship order being stopped when it is still needed. This could put the person at risk, especially with the shortened review times which could double the case load of social workers without the change in the burden of proof.

11. Are the safeguards for patients sufficient, particularly for children, young people, and those with learning disabilities or neurodiverse conditions?

Safeguards to prevent the accessing of less appropriate services such as hospitalisation when community-based treatment or services may be more appropriate is covered within the proposed legislation. This is especially true for those with learning disabilities and autism who are specifically identified within the legislation changes.

There are however concerns in regard to the appointment of a Nominated Person and how best to safeguard in this area. There are two main areas of concern. The first is for children aged 16 and 17, who remain a child but are treated as an adult in the legislation and has the potential to appoint a peer who is also 16 or 17 to act as their nominated person. Given the individual is in a mental health crisis they are in a more vulnerable state and may be exploited for reasons, such as bullying, criminal exploitation or abuse. We are also concerned that there is the potential that a child of 16, or a young carer, may be given responsibility for someone as a form of coercion or abuse, forcing them to take on more responsibility and place them in a situation where they feel unable to refuse. This could be caused by exploitative behaviours or abuse by either the person nominating them or through influence of a third party or perhaps controlling behaviour such as playing on a sense of duty where it is perceived by the young person that they have no choice. The United Nations Convention on the Rights of the Child identifies that a child is anyone under the age of 18 and we would therefore advocate that the age for all under 18s is for the Nominated Person to be over 18.

The other concern is around the risk of criminal exploitation through either individuals or organised crime gangs. Whilst the legislation under schedule 2 specifies that the age of the person must be as laid out in the legislation (over 18 for under 16 and 16 or over for those 16 or over) and must not be a person disqualified by 30B(6) (which means the person has been terminated as a Nominated Person by a court order,) this leaves the potential for exploitation by criminals known to the criminal justice system but not to mental health professionals (and others) appointing the Nominated Person unless the person has already been disqualified by the Court. One such concern could be that someone involved in cuckooing (taking over a vulnerable persons home for illegal purposes, such as county lines) may be a nominated person named by the individual and with no known criminal activity who then uses the system to gain additional access to the house with the person either trapped even more in the home with them or pushed into the hospital, so the nominated person has free rein of the house and no external bodies are coming in to provide care etc.

Whilst there is abuse within families, we think that one of the potential ways to reduce this risk is for a DBS or other faster check to be carried out on anyone given Nominated Person authority but with no family or checkable relationship. There is abuse within families so this will not stop all forms of abuse, but it should help reduce and limit the possibility.

Transfers from prison to hospital: time limits

12. Your views on proposals to introduce a statutory 28-day time limit within which individuals with a severe mental health need must be transferred from prison to hospital for treatment under the 1983 Act.

We agree in principle that individuals should receive the most appropriate services to support them, delivered as close to home as possible. In this instance, that would mean people requiring mental health crisis treatment due to severe mental health should be treated in appropriate health facilities.

The legislation as it is currently written puts a requirement on the Local Health Boards to take people from the prison estate and into hospital within 28 days. If the responsibility is placed on the Local Health Board where the prison is situated, then this will put additional pressure on those areas. There are five prisons currently in Wales based in five of the seven health board areas:

- Aneurin Bevan University Health Board – HMP Usk and it's satellite site of HMP Prescoed (488 prisoners in August 2024).
- Betsi Cadwaladr University Health Board – HMP Berwyn (1,976 prisoners in August 2024)
- Cardiff and Vale University Health Board – HMP Cardiff (739 prisoners in August 2024)
- Cwm Taf Morgannwg University Health Board – HMP Parc (1,805 prisoners in August 2024)
- Swansea Bay University Health Board – HMP Swansea (426 prisoners in August 2024)

Cardiff University in their report Prisons in Wales 2022 Factfile, which was published in November 2023, identified that there was an increase of people from England being held in Welsh prisons by 155 per cent since HMP Berwyn was opened in 2017. In 2020, there were enough people normally resident in England placed in Welsh prisons to fill HMP Parc (1,640 people). This has resulted in Wales having the highest in-country imprisonment rate in Western Europe at 177 per 100,000 of the population in September 2023, compared with 146 per 100,000 in England.

The Prisoning and Sentencing in Wales Factfile 2023 published in October 2024 provided more up to date information specific to 2023 alongside the numbers being held in August 2024 in each of the five prisons which make up the prison estate in Wales. It found an increase of around 16% from the 2022 average it reported in the number of prisoners held in August 2024 across the Welsh prison estate. One third of the prisoners held in Welsh prisons were from England, remaining consistent with the numbers that HMP Parc holds. There was also an increase to the number of English prisoners held in Wales by 191 per cent since 2017.

Given the size of the prison populations based in HMP Berwyn and HMP Parc in comparison to the local population these two Local Health Board areas are likely to be particularly impacted. Whilst there are no category A or women's prisons in Wales, who would all receive

treatment from the NHS provision in England under the legislation, those who may receive treatment will be in hospitals away from home and their possible support network.

Due to the size and number of those who live in England being placed in Welsh Prisons the calculated funding consequential is likely to be low, especially if based on the population ratio per 100,000 of the population. This would leave Wales under funded by 31 people per 100,000 or 961 across the whole of Wales (based on 3.1m Welsh population). To put this in context, in 2022 the Welsh Prison population was on average 4,682 (Cardiff University), under the consequentials proposed 20.5% would not be funded. As a response to this likely deficit, Wales would be required to pull more funding from health, housing and social care to fill the gaps and put more pressure on local government budgets.

There is also a risk that the 28-day statutory requirement could mean that beds that would have been available for those not in prison are no longer available to those in the community. There is a real possibility that those who have committed felonies are prioritised whilst those in-need in the community are unable to access beds. As a consequence, this is likely to place additional pressure on Housing and Social Services to provide community-based interventions and support which may not be as efficient and effective for the patient and funded by local government when they should be covered by Health within the secondary health estate. This could mean that for those most desperate they may take to criminal activities with the aim of accessing the support they require, this has been seen anecdotally with substance misuse services and remand prisons. This is at a time when the implementation of Right Care, Right Person (which reduces the police response to mental health episodes in the community) is already expected to put unfunded additional pressures on community housing and social care services and increase safeguarding concerns.

We therefore believe that the funding consequential impact needs to be revisited and not to base the funding for Wales on the normal consequential formula but on the prison population itself and the higher in-country imprisonment figures that Wales carries than England due to the number of those normally resident in England who are placed in Welsh prisons.

Help and information for patients

13. *Your views on proposals to place a duty on Local Health Boards in Wales to make arrangements they consider appropriate for making information available about advance choice documents ("ACD") and helping those people they consider appropriate to create ACDs.*

Regarding the duty itself we have no comment or view as it will be a duty on health colleagues. We do have an equalities concern regarding 'helping those people they consider appropriate' as this is fairly ambiguous and could result in inconsistency over who receives help and who does not based on geography, or which professional is being engaged with and could be impacted by types of disability or race and leave Local Health Boards open to claims of discrimination.

Early intervention and community based support

14. Are the provisions for crisis intervention and preventive care adequate and in line with the Welsh Government's focus on early intervention and community-based support?

The explanatory note, LCM and SLCM and the legislation appears to focus on managing the crisis and hospital elements of mental health crisis, and not on the early intervention and community-based support. Therefore, we are not sure that the provisions for crisis intervention and preventative care are adequate.

The role of social care and housing is mentioned rather than built on and how it should or will be developed included. There is acknowledgement that the Bill will add to requirements on health, social care and housing, but if early intervention and community-based support is to be truly delivered then other devolved matters are involved, including: comorbidities with substance misuse and Violence Against Women Domestic Abuse and Sexual Violence; education for children and young people; community safety and public order.

The new Mental Health Strategy is due shortly and we hope that early intervention and community-based support will be a focus by the Welsh Government in line with other legislation such as the Social Services and Wellbeing (Wales) Act 2014. However, without the strategy and the Suicide and Self-Harm Prevention Strategy which is also due it is difficult to say whether the Mental Health Bill is in line with the new Welsh Government strategies.

There is a continued focus on discharge from hospital without recognition of the work being undertaken with community-based settings to prevent hospital admissions or further escalation of illness which raises concerns over whether we have the right focus on prevention and early intervention in Wales. The change in when hospitalisation can occur has the potential, if the funding follows, to allow some of the prevention and early intervention to be expanded, but it also comes with a possibility that support will not be available from health outside of crisis resulting in the help people need not being present and more people ending up requiring crisis services.

Removal of police stations and prisons as places of safety

15. Your views on proposals to remove police stations and prisons as a place of safety for adults experiencing a mental health crisis.

It is noted that the proposal to remove police stations as a place of safety for individuals experiencing mental health crisis has been on a trajectory for some time, with changes implemented in 2017 prohibiting children from being taken to police cells as a 'place of safety', the need to consult with Mental Health practitioners and changes to where mental health assessments could take place following Section 135 warrants as examples (see New rules restricting the use of police cells as places of safety come into effect - GOV.UK). As such, the proposal for adults experiencing a mental health crisis would appear to be consistent with these previous developments and is supportive of the principles Right Care,

Right Person. We agree that where possible people should be seen by appropriately trained individuals in a place where they can access the most appropriate help and treatment.

However, as we mentioned in our response to question 12 there is a risk of an unintended consequence of an improved level of access for those in the criminal justice system than those outside of it.

Throughout the implementation of Right Care, Right Person (RCRP) we have raised concerns about the potential impact on devolved areas of health, housing (including homelessness) and social services and the fact that the pilot for RCRP included funding being moved from health to local government, and yet, during the national (England and Wales) roll out by the Home Office no additional funding followed. We have also raised concerns about the speed of transition and potential negative impacts on individuals; carers and local communities; charities or community-based support services. The removal of police stations as safe places for adults is likely to add to this. Following the changes to legislation around children not being taken to police cells as a place of safety we are aware that there were difficulties identifying secure, local alternatives, with individuals known to have to travel many miles to be accommodated, and difficulties around staffing out of office hours.

We accept that police cells and prisons are not the place we would like people experiencing a mental health crisis to be in and recognise the environment may exacerbate the crisis being faced; however, it is possible, if not likely in some cases, to be the safer option for individuals, staff members and other vulnerable people rather than leaving them at emergency departments without suitable support. In some parts of England under RCRP reports of such circumstances have been made, or individuals have been left in the community where they continue to be a risk to either themselves or someone else (including social care staff) until appropriate support can be accessed. If a person remains in a care home with other vulnerable individuals because the bed they would have been given is now prioritised for someone in the criminal justice system, trying to safeguard for staff and other care home residents becomes increasingly complex.

Until such time that adequate provision, additional support services/ beds and expert mental health care professionals are available there is an argument that a prison or police cell being used as a safe place is the most appropriate in order to protect other vulnerable people who, through the mental health crisis of someone else, are at significant risk of harm.

For this to be effective we would suggest that there needs to be an appropriate transition to allow the systems and processes to be put in place to prevent escalations in incidents in the community and a negative impact on safeguarding. This transition should be continually monitored and only moved to full implementation when systems and processes are in place and full implementation can be done so safely, this could be a staggered increase that can be managed safely. This would provide safeguards in the system, ensure compliance and enable the expansion of services or additional crisis support in the community to be established and sourced. However, it will be essential for this to be funded and therefore it is important that any consequential funding that is received is ring-fenced for delivery and split appropriately between health and social care and housing, and not all focussed on health.

Unless there is an increase in bed capacity in health then it will be the housing and social care sectors that carry the most weight in the delivery of the legislation. The already complex issue of accessing hospital mental health beds will become more difficult and lead to those in deeper mental health crisis who should be receiving in-hospital treatment receiving services through social care, housing and other local government services.

Children and young people

16. Does the Bill adequately consider the needs of children and young people in Wales, particularly given the higher rates of mental health concerns reported post-pandemic?

There is some concern about the nominated person process for under 16s. Whilst we appreciate the fact that their nominated person must be 18 or over, there needs to be some reference to both the responsibilities that parents and guardians carry, and the corporate parent responsibilities of the public sector. The risk otherwise is of someone slightly older such as an 18year old being able to coerce or exploit a 15-year-old by encouraging them to make them the Nominated Person.

Clause 36 in regard to the transfer directions for persons detained in youth detention accommodation would appear consistent with ensuring that a child or young person receives the care in the most appropriate setting, which in the case of a severe mental health episode may be a young persons mental health bed in a ward or hospital.

There is an increase in need and the need for more community based mental health services to prevent escalation to mental health crisis. The Bill as it currently stands does not focus on the delivery of preventative services or early intervention to prevent escalation into more serious mental health and this may be a missed opportunity. The impact assessment that accompanies the Bill identifies the impact on health, social care and housing but not on education, youth offending services or community youth programmes all of which are likely to be impacted by the provisions and may need to put in place internal policies for if a staff member or volunteer are named as a Nominated Person with or without the employers knowledge.

We agree with the position the Bill takes in regard to autism and learning disability and that no-one will be hospitalised under mental health unless they are having a psychiatric episode. This builds on ensuring that people are cared for in the most appropriate settings and services, and on strength-based community services. This should see a change in funding from hospitals to primary health and to councils for delivering social care services as well as for education who may need to increase support to enable the continuation of attendance in a school setting.

The Bill and Explanatory Notes do not appear to make reference to the higher rates of mental health concerns reported in Wales post-pandemic but it does not conflict with any of the legislation and policy direction in Wales. The implementation of the Bill may require additional training for the education, social care and housing workforces on behaviour management and

mental health first aid, and an increased provision of school-based support and counselling services to enable early intervention and prevent escalations.

There has been reporting since at least 2019 on the shortage of child mental health beds in Wales, with the Royal College of Paediatrics and Child Health reporting that there were just 3 beds per 100,000 children in Wales in comparison with 11 per 100,000 in England. This may be due to the differences in mental health services but could cause issues at implementation with the Bill not addressing this shortage. It could potentially add to the shortage, with up to 46 under 18s being placed in HMP Parc with Cwm Taf Morgannwg University Health Board having 15 beds for 12-18 year old mental health patients and housing all of the prison population of under 18s in Wales with England prisons holding all those 16 or under.

There are already sufficiency issues within social care for children and the Health and Social Care (Wales) Bill may further add to these issues with a potential impact on some of the small specialist services for children and young people with mental health issues. As a result, implementation of the Mental Health Bill may add to the sufficiency issues due to the statutory 28-day prison to hospital requirement at the same time that Right Care, Right Person is being implemented by the Police across Wales.

Workforce

17. What impact will the Bill have on mental health practitioners and services in Wales, particularly in the context of staffing pressures and workforce development?

The Social Care Workforce is already under intense and well documented pressure, this applies to mental health practitioners and services just as much as other social care services. In addition, the Bill is likely to increase the pressure on safeguarding and safeguarding teams which may add to the resource issues for Social Workers alongside other social care staff. The social care sector already has recruitment and retention challenges which could be further exacerbated by the need to deliver more services to people in a mental health crisis who should be in hospital but there is no bed available.

There is the potential for the Bill to lead to a decline in morale due to social care staff (along with those in housing) being left with a feeling that the people they care for are forgotten and less visible. A bed could become free in a mental health hospital or ward and it could potentially be taken by a less unwell patient who is prioritised not over need but because of the 28-day statutory requirement for them to be moved from prison to hospital. In a strength-based system it is difficult to see how access to a bed may not be based on severeness of the illness but on if they are in the criminal justice system or not.

There may be additional risks that need to be managed in the community due to increased behaviour and violence linked to the severe mental health episode that the individual is experiencing which may mean that a provider (commissioned or Council provided) will need to increase the number of social care workers who need to attend for care to be provided

safely for all involved. This will automatically put more pressure on both council budgets and on already stretched resources especially the shortage of social care workers.

There is one final unintended consequence for consideration, which could be a reduction in social care providers willing to take more complex cases including where there are known mental health issues, or who return a contract to commissioners due to the behaviour of the individual and the unwillingness of staff to attend or be put at physical risk of harm themselves. If a provider thinks that if a crisis occurs they will be left to manage a situation that requires medical treatment and intervention and anticipates that support will not be there for them and they will be prioritised below less ill individuals then there could be an additional challenge of no provider being willing or able to take that risk.