The below is Adferiad's response to the Senedd Cymru's Health and Social Care Committee's call for evidence to inform their scrutiny of the Legislative Consent Memorandum on the UK Government's Mental Health Bill.

Adferiad is a member-led charity that campaigns for and provides services to people affected by mental ill health, serious mental illness, drug or alcohol use, gambling harms, and other challenging circumstances. We have over 750 staff and 100 plus volunteers, who support more than 30,000 clients each year. We deliver services in all twenty-two counties of Wales, and in Lancashire we provide services for people from across England. Our expert staff and volunteers apply a whole person approach to treat people as individuals and support them to achieve a better quality of life. We are rights affirming people within a rights-affirming organisation.

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 effect of Clause 1 of the Bill is that the secretary of state in relation to England, and Welsh ministers in relation to Wales, will be required to include the four principles (established as a part of the Wessely review) in the statement of principles in the Code of Practice, and that these principles should inform relevant decisions under the Act.

The four new principles are:
- Choice and autonomy
- Least restriction
- Therapeutic benefit
- The person as an individual

The effect of Clause 2 of the Bill is to amend the Act to extend to Wales the same requirement to include a statement of principles in the Code and ensure it addresses the same matters as is required in relation to the Code in England.

Unlike the current "guiding principles", which are set out in the Code of Practice for the Act, Wessely's report recommended that the four principles and the following purpose be incorporated into the Act itself; 'The purpose of this Act is to confer and authorise the powers (including coercive powers) necessary for the treatment of mental disorder and to safeguard the dignity and rights of those who are made subject to the exercise of such powers and for related purposes.'

Wessely's report said:
'We also think principles should be incorporated into the Mental Health Act. There are already guiding principles in the Code of Practice. However, there is limited awareness of these, and it seems very likely that they do not inform practice in the way they should. Further, we have heard from both service users and professionals that they have welcomed similar principles that are set out in the opening section of the Mental Capacity Act 2005.'

The previous Joint Committee of the House of Commons and House of Lords that scrutinised the previous Mental Health Bill introduced by the last UK Government recommended that 'the principles underpinning the 2018 independent review, and respect for racial equality, should be included on the face of the Act. The previous UK government disagreed with this recommendation.

The current Code of Practice for Wales already includes six guiding principles, dignity and respect, least restrictive option and maximising independence, fairness equality and equity, empowerment and involvement, keeping people safe, effectiveness and efficiency. It states that 'the guiding principles ... should always be considered when making decisions about a course of action under the Act.

Adferiad has long called for principles to be integrated with legislation, and we agree with both Wessely and the Joint Committee that the 4 principles should be included on the face of the Bill and not be 'relegated' to a code of practice.

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

The proposed Clause 3 of the Bill would have the effect of preventing people from being detained for compulsory long-term treatment under section 3 of the Act on the basis that they have a diagnosis of autism or learning disability. It does not prevent individuals with such conditions who have a co-occurring mental disorder from being detained for that co-occurring condition, and Adferiad believes that this is a significant step forward in recognising the difference in needs but definition of mental disorder will be key.

Clause 4 does not apply to Wales and relates to people with a learning disability and those with autism being subject to detentions that may not meet their needs and provide little or no therapeutic benefit. It makes it a statutory requirement to hold Care (Education) and Treatment Reviews for patients with a learning disability or autistic people. This is currently policy in England and will become a statutory requirement. These reviews are not policy requirements in Wales.

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

Many of the duties and rights set out in the current Act relate to care and treatment that are matters devolved to Wales and which take legal effect through both the Mental Health (Wales) Measure and through the Social Services and Wellbeing Act (SSWBA). There has been a long-term problem in Wales in voluntarily accessing mental health services, and sometimes the only way someone may gain access is through being detained under the Mental Health Act. There has been a lack of easily accessible early intervention services.

Care and treatment planning, particularly for people with severe and enduring mental illness, has been poor despite this being a requirement under the groundbreaking mental Health (Wales) Measure. Clause 20 of the Bill introduces statutory care and treatment plans (CTPs) for all patients formally detained under the Act, excluding those under short term sections. This applies to England only as 'there is similar provision already in place in Wales'. The main purpose for introducing this clause is to ensure all 'relevant patients' have a plan in place describing what is needed to progress them towards recovery and their timely discharge from the Act.

The scope of this proposal is to include meeting the patients' needs in relation to their care, treatment, leave, and eventual discharge, and CTPs will also be used to provide evidence about clinical decisions, such as the reasons behind the person's detention, as well as evidence of how the patient and those close to them have been included in care and treatment decisions. The intention is to ensure greater

transparency and scrutiny around clinical decision making, such that the use of restrictive practice is only used when there is 'robust justification'.

Although there is a duty under the Mental Health (Wales) Measure 2010 for all 'relevant patients' (including informal patients) in Wales to have a Care and Treatment Plan, the intention, and the scope of these is somewhat different and they serve additional purposes. CTPs in Wales are mandatory for people detained under the Act and those under secondary mental health services. While there is no requirement to include specific treatment decisions, and they are not intended to be used or considered at Tribunal hearings, this does not mean that they could not be in the future

The proposals relating to new statutory CTPs (for England only) are centred on them including 'the full range of treatment and support available to the patient from health and care organisations' as well as whether any care could be delivered without compulsory treatment, least restriction, areas of unmet need, etc.

Consideration should be given on whether it may be necessary to amend the format of the CTP in Wales to reflect shared decision making relating to treatment decisions. This is likely to require new regulations being introduced in Wales. We also need to consider how to strengthen CTPs in Wales so that they are consistent with the care and treatment duties set out in the Bill.

Impact on devolved competence

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

Whilst the idea of Westminster legislating in areas that are devolved is ostensibly contradictory to the devolution settlement, we understand that such action may be appropriate where a piece of related legislation operates on an England and Wales basis and any corresponding law will need to reflect that. However, many of the areas covered in the Bill to amend the Mental Health Act can and should be taken forward by Welsh Government. One example relates to Advance Choice Documents (ACDs) (Clause 42). The Bill inserts new sections 130M and 130N into the Act which create new duties on ICBs, NHS England and Local Health Boards in Wales in relation to facilitating people to make an Advance Choice Document.

ACDs are intrinsically linked to care and treatment planning which is a devolved matter and is part of the Mental Health (Wales) Measure 2010. The advantages of WG amending legislation to legislate for ACDs in Wales is that it can be introduced faster than would otherwise be through the MH Bill.

Wales is already ahead of England in having primary legislation that states that all relevant patients[1] must have a prescribed care and treatment plan – and this includes recording any views, present wishes, or advance statements the patient wants included in their plan. It seems therefore totally appropriate for ACDs to be a matter for the Welsh Government to consider and not the UK Government

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?*

There are five main pieces of legislation that have varying impact on mental health services in Wales. Three of these are devolved and two are non-devolved and apply across both Wales and England. The legislation that has the greatest impact on mental health services in Wales is the Mental Health (Wales) Measure.

Devolved legislation:

- Mental Health (Wales) Measure 2010
- Social Services and Wellbeing (Wales) Act 2014
- Wellbeing of Future Generations (Wales) Act 2015

- Non-devolved legislation:
- Mental Health Act 1983 (revised 2007)
- Mental Capacity Act 2005

Wales has its own separate Code of Practice relating to the Mental Health Act and a Code of Practice for parts 2 and 3 of the Mental Health (Wales) Measure. The Code of Practice for the Mental Capacity Act covers both Wales and England.

[1] Mental Health (Wales)Measure 2010, s.12 Meaning of "relevant patient"
(1) For the purposes of this Part, an individual is a relevant patient if a mental health service provider is responsible for providing a secondary mental health service for the individual…

Welsh Government's proposed new mental health strategy and the Mental Health (Wales) Measure have the potential for achieving what Simon Wessely's landmark review set out to do; reduce reliance on detention and compulsion under the Mental Health Act and ensure appropriate and timely services are in place when people need them. Given the differences in health and social care systems between Wales and England, we need to consider how much divergence there should there be in mental health legislation across the two countries.

We believe that detentions under the Mental Health Act can be reduced by ensuring the Welsh Government's mental health strategy is implemented and by enforcing the Mental Health (Wales) Measure. Applying these two principles would help reduce detentions under the Act by ensuring:

- That resources are targeted efficiently on moving those patients receiving higher-end (and more expensive) services, where appropriate, into lower-level support services, as this will have the greatest impact in terms of improving people's lives - and additionally in reducing the cost of their care and treatment;
- That intervention is provided at the earliest possible time. Conditions such as schizophrenia and bipolar disorder often require high levels of care and treatment, and by providing this at the earliest possible point we can greatly improve outcomes for people and potentially reduce care and treatment costs

Both the human cost and the financial cost should be considered when developing service models. Recovery-focused services that are co-produced are more likely to result in better outcomes for service users/patients and a reduction in financial cost. We believe that prudent healthcare and value-based principles should be incorporated into all future mental health modelling proposals.

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

We believe that Welsh priorities and policies should be determined in Wales by Welsh Government through strengthening the Mental Health (Wales) Measure and through implementing the new mental health strategy. We believe that, if successful, this will reduce the number of people detained under the Mental Health Act.

Cross-border considerations

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

The Bill has the potential to address the movement of patients across the Wales-England border. By ensuring consistency and a coherent legislative framework, and having the same rights and duties in both nations, this will mean an equally consistent and coherent experience for those Welsh citizens in receipt of care across the border in England. Specific focus should be given to ensuring that care and treatment plans are consistent across both nations.

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".*

If a person has a learning disability or autism without an accompanying mental health condition, under the proposed regime there would be no basis for longer term detention under s 3 of the Mental Health Act, but it would still possible under the Mental Capacity Act DOLS. Hence the likely result of appearing to restrict powers to detain under the Mental Health Act may lead to an increase in detention under the Mental

Capacity Act, which provides a much less rigorous regime of safeguards around detention and treatment without consent than the Mental Health Act.

It will still be possible to detain patients with autism or a learning disability for assessment under s 2, (up to 28 days), and under s 3 for treatment for up to six months if they have an accompanying mental health condition which would benefit from treatment. The provisions defining mental disorder leave immense scope for clinical discretion.

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").*

CTOs were introduced in the 2007 revision of the MHA and have been subject to high levels of criticism ever since. They mean that a person can still be subject to conditions after they are discharged from hospital and be recalled if concerns about their need for treatment develop. Many people believe that they have been overused, and the number of people subject to a CTO is far higher than anticipated before they were introduced. 'Black or Black British' people are over eight times more likely to be given a CTO than white people.

Some organisations, previously opposed to the introduction of CTOs, now accept that there are a small number of people for whom CTOs represent the least restrictive option, though we note the Wessley review's comment that CTOs are "in the last chance saloon"

Clause 21 amends s17a of the Act to require a community clinician to be involved in decisions regarding the use and operation of CTOs, including decisions to make a person subject to a CTO, to vary or suspend conditions made under a CTO, to recall to hospital a patient subject to a CTO, and to revoke a CTO after a patient has been recalled.

This clause also makes a distinction between a patient's 'responsible clinician', who has overall responsibility for the patient including in hospital, and a 'community clinician', who has responsibility for the patient in the community. Clause 21 (3) (b) inserts the following into the Act, 'where the responsible clinician is not the community clinician, the responsible clinician must consult the community clinician before varying or suspending conditions specified in a community treatment order, unless consultation would involve unreasonable delay.'

The Bill stops short of adopting all the recommendations made by Wessely, crucially that CTOs should have an initial period lasting 6 months, renewed at 6 months and then at 12 months, and that CTOs should end after 24 months. Wessely also recommended that the recall criteria should be updated, and the process should be reformed to make it simpler. The appropriate use of CTOs under a new Act will clearly be a test as to the effectiveness of any new legislation.

Nominated person

9. *Your views on:*
    a. *the proposed introduction of a "nominated person" role to replace the nearest relative in decision-making;*
    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?*

There has long been criticism of the current method of determining the 'Nearest Relative', and that this needs to change. Currently a person detained under the Act has no say over who fulfils this role where someone is automatically appointed through a hierarchical list of conventional relatives. Clause 23 of the

Bill introduces a new statutory role to the Act, the 'nominated person', to replace the 'nearest relative'. The main intention is that the patient will be able to personally select a nominated person to represent them and exercise the relevant statutory functions that the Bill extends. Following detention under the Act, a patient would be able to nominate someone to be their nominated person at any time when they have capacity/competence to do so. They can also nominate someone in advance of the detention, or when they are being assessed under the Act.

If someone lacks capacity/competence to make a nomination, and has not previously nominated anyone, a nominated person can be appointed by an AMHP. They can be in place until the person has the capacity/competence to make their own nomination and does so. It will therefore be important to take all possible measures to ensure that people can nominate someone before they become unwell, and use Advance Choice Documents as one way of doing this. Adferiad welcomes the proposed safeguards included with these proposals.

We welcome the Bill proposing that existing powers of a nearest relative will be transferred to the new nominated person role that includes:

- The right to require an assessment to be made with a view to admitting the patient to hospital
- The right to apply for compulsory admission or guardianship
- The right to be consulted or informed before an AMHP makes an application for detention under section 3 or guardianship
- The right to section 3 admission or guardianship
- The right to order discharge of the patient
- The right to information given to the detained patient or patient subject to supervised community treatment
- The right to apply to the Tribunal

In addition to existing powers, the new nominated person role will be given the following new powers and rights:

- A right to be consulted about statutory care and treatment plans (although as previously noted, CTPs envisaged under the Bill do not apply to Wales)
- A right to be consulted about transfers between hospitals, and renewals and extensions to the patient's detention or CTO, and
- The power to object to the use of a CTO

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 subject matter of the Mental Capacity Act is a reserved matter and no aspect of it is devolved to Wales. Wessely's review recommended there be a clearer dividing line between the MCA and the MHA. The previous UK government sought views on where the dividing line between the two Acts should be. There was a mixed response, and the previous government said it would review the interface after the implementation of the new Liberty Protections Safeguards (LPS), which will replace the Deprivation of Liberty Safeguards (DoLS). The LPS has not yet been implemented.

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

We are unable to make specific comments and recommendations, although we would support any steps to ensure children, young people and those with learning disabilities or neurodiverse conditions receive

the right and appropriate level of patient safeguards and support consistent with their diagnosis or condition.

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 support the principle of ensuring individuals with a severe mental health receive the right and appropriate level of support consistent with their diagnosis or condition, in the right and appropriate setting, in a timeframe that is practical and safe, and not unnecessarily extended. If a prisoner requires treatment, this must be equivalent to that provided for patients not held in prison, and without any time limit, there is a risk that such provision may be denied for long periods.

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.*

We believe that the duty should be for patients to have an Advance Choice Document unless they choose not to do so, not merely rely upon Health Boards making 'arrangements they consider appropriate'.

The Bill inserts new sections 130M and 130N into the Act which create new duties on ICBs, NHS England and Local Health Boards in Wales in relation to facilitating people to make an Advance Choice Document.

This can be used by people to set out what they want and don't want, while they are well and have capacity or competence to do so and can be used by mental health professionals if they are assessed and potentially admitted for care and treatment either formally or informally, and they lack the capacity or competence to share these things at the time.

Clause 42 (3) (b) states that ACDs only come into play when a person lacks capacity. For that to happen then capacity would need to be assessed each time a decision needs to be made that is included in an ACD. It is not yet clear how this will work in practice, e.g. if a person is detained but doesn't lack capacity but is nevertheless in a distressed state and not able to articulate or explain their wishes, feelings, or decision on a matter, the way the Bill is worded, an ACD would not be applicable.

Wessely said that as the Care and Treatment Plan would include reference to the ACD, a Tribunal would have it before them at each hearing considering discharge. It would therefore be able to consider the extent to which the overall care and treatment plan complied with the patient's wishes and preferences as stated in advance. This would be particularly important in any application brought on behalf of a patient where they did not have capacity to do so and might well also lack capacity to make decisions as to treatment.

We expect details on the format and what needs to be included in an ACD to be included in a new code of practice or in regulations. Given that the duty relating to Care and Treatment Plans is for England only, and Advance Choice Documents are for both England and Wales, Welsh Government may need to consider how these arrangements will practically work in Wales and are consistent with practice in England.

ACDs are intrinsically linked to care and treatment planning which is a devolved matter and is part of the Mental Health (Wales) Measure 2010. The advantages of WG amending legislation to legislate for ACDs in Wales is that it can be introduced faster than would otherwise be through the MH Bill.

Wales is already ahead of England in having primary legislation that states that all relevant (eligible) patients must have a prescribed care and treatment plan – and this includes recording any views, present wishes, or advance statements the patient wants included in their plan. It seems therefore totally appropriate for ACDs to be a matter for the Welsh Government to consider and not the UK Government.

Wessely's report said that ACDs should have a standard format. They should enable people to make a range of choices and statements, including:

- Treatment preferences (including non-medical therapeutic approaches)
- Treatment they do not want (refusals)
- Preferences/refusals on how treatments are administered (e.g. refusal of suppositories)
- Nominated Person
- Who should be informed of their detention, care and treatment (with the potential to tailor for specific individuals)
- Communication preferences
- Behaviour and behaviour triggers and early signs of relapse
- Circumstances which may indicate that they have lost capacity to make relevant decisions
- Religious or cultural requirements
- Other health needs and/or reasonable adjustments required for disability
- Crisis planning, including information about care of children/other dependents, pets, employment, housing etc.

Wessely also recommended that patients should have greater rights to choose to disclose confidential information to additional trusted friends and relatives, including through the Nominated Person nomination process or advance choice documents.

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?

There is little in the Bill to address crisis intervention and preventative care, although Wessely had a number of recommendations to help begin to address this. Many of the Wessely's original recommendations did not relate to legislation but to policy, e.g. -

- Rec. 35. There should be more accessible and responsive mental health crisis services and community-based mental health services that respond to people's needs and keep them well.
- Rec. 36. Research should be carried out into service models and clinical/social interventions that affect rates of detention.
- Rec. 37. The Government should resource policy development looking into alternatives to detention, and prevention of crisis.

There is currently no evidence to suggest that either the Mental Health (Wales) Measure or implementation of Welsh Government policy has resulted in fewer detentions under the Act. Several reviews in Wales have found that the delivery of the care and treatment planning process is ineffective in terms of benefits to people using mental health services. Responsibility for crisis care now sits with the Wales NHS Executive, and there is a new Acute and Crisis Care work programme.

We should consider how the provision of acute and crisis care is covered and included in legislation in Wales (as suggested by a previous Health, Social Care and Sport Committee report). If it is not covered sufficiently, we need to look at how can we strengthen and make better use of existing legislation in Wales to improve crisis and crisis prevention services.

We must find ways to reduce the disproportionate number of people of Black people who come into contact with mental health services through the criminal justice system rather than through their GP. It has long been known that Black people are more likely than any other ethnic group to be detained under the Act, and we need to urgently address this in Wales.

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.*

Clause 46 removes police stations as places of safety when the police are exercising their powers under sections 135 and 136 of the Act. This is because it has long been known that police cells are not suitable environments for people with a severe mental health problem, in crisis and awaiting assessment and treatment. Clause 46 also removes police stations and prisons for Part 3 patients, although, not for those already detained in a police station or prison when the changes commence.

In June 2024, out of 551 detentions in Wales under s136 only five were where a police station was used as place of safety. Two were not recorded, 366 were in a health-based place of safety – but 178 s136 detentions was where an Emergency Department (ED) was used as first place of safety.

Royal College of Psychiatrists guidance states, 'The emergency department should only be used as the place of safety where medical problems require urgent assessment and management'.

Royal College of Emergency Medicine guidance states: *"There will always be a group of people detained on s136 who need to attend ED for physical health needs therefore thought must be given to providing appropriate staff training (including security) and assessment areas"*.

'ED can only take over the legal responsibility for a s136 detention if they have the staff and space to ensure the wellbeing of the patient and ensure they do not abscond. Case law, the 'Webley' case[2] ,

[2] Webley v St George's Hospital NHS Trust & Anor, Court of Appeal - Queen's Bench Division, February 14, 2014, EWHC 299.

highlighted that EDs could be liable in negligence law if they agree to take on legal responsibilities and the person then absconds'

The use of police stations as a place of safety under s135 and s136 of the Act is no longer such an issue in Wales. In June 2024 an ED in Wales was used as first place of safety in around 30% of detentions under s136 compared to less than 1% of detentions where a police station was used. The issue is the potentially inappropriate use of an ED, and further work is needed in Wales to find ways to reduce this.

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?*

We are unable to make specific comments and recommendations, although we would support any steps to ensure children and young people receive the right and appropriate level of support consistent with their diagnosis or condition, which may involve the Welsh Government creating a specific framework for assessing the capacity for under 16s.

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?*

We are not in a position directly comment on the staffing pressures and workforce development within NHS or local authority services. However, when looking more broadly at this topic, it is crucial to acknowledge that holistic care and treatment for individuals subject to the Mental Health Act nearly always involve NHS/ health staff, social care professionals, and both commissioned and non-commissioned third-sector services. Often, it is these third-sector organisations, such as Adferiad, that engage with individuals most frequently, providing consistent, day-to-day support. Many third-sector organisations rely on commissioned contracts, several of which have remained uninflated for over a decade, leaving us operating on reduced budgets and unable to match the pay and terms offered by Agenda for Change roles, and now the increase in National Insurance. Too often, we see new mental health practitioners entering the field through third-sector organisations, where they are trained and introduced to the sector while working in partnership with health boards and local authorities, only to be recruited by health boards offering more favourable terms. While this may address immediate staffing shortages within health boards/statutory mental health services, it weakens the overall pool of mental health practitioners in Wales and undermines the long-term sustainability of the sector.

Summary

We broadly accept that the Bill would improve the rights and safeguards for people in Wales and England, we also believe that the Bill could be strengthened in some areas, as set out above, and that particular consideration be given to the implementation of Advance Choice Documents and Care and Treatment Plans, so that consistency across devolved competences is ensured.

We welcome your scrutiny of the Legislative Consent Memorandum and the Bill, and would be happy to discuss further any aspect of the above response.

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