

## **Written evidence submitted by Ms Jo Roberts supported by Adferiad Recovery (MHB0036)**

### **About me**

I am a mental health campaigner who was on the receiving end of the Mental Health Act for over 30 years. I have been subject to compulsory treatment a few times in my life and some of that treatment was deeply unpleasant and even terrifying. I was sectioned for long periods: until 2020 I was subject to a Home Office section. Having been through this, I strongly feel that we need a system that works as hard as possible to prevent people from needing to be detained, and that treats them with respect when there is no choice but to compel them.

I am campaigning for a progressive Mental Health Act fit for the 21st Century – an Act that gives patients and carers in Wales and beyond a fairer deal and which is therefore the patient's friend rather than a threat.

I originally campaigned for a fair Mental Health Act back in the early noughties when a draft new Bill was being considered by Parliament. I gave evidence in person to the Joint Scrutiny Committee in Parliament and played my part in seeing off a new draft act which was not taking us in the right direction at all. We then ended up with an amending act which modified parts of the 1983 Mental Health Act.

I have talked to over 100 service users and carers about what it's like to be on the receiving end of the Mental Health Act and I've been in touch with thousands more on social media and through Jo's Blog which I have been publishing since early 2019. My views here are based on that conversation as well as my own experience.

I support having laws which make it possible in limited circumstances to detain innocent people with a serious mental illness - because I'm a realist: society cannot stand by and let somebody who has lost touch with reality injure themselves or, worse still, take their own life. And of course sometimes people who are very ill can pose a threat to others – their family or members of the public – and we have a duty to protect them too.

My concern is about how these laws are framed – and I make no secret of my longstanding determination to wholly replace the current Mental Health Act with a new law which can do a better job of protecting everybody and also reduce the use of compulsion.

### **About Adferiad Recovery**

Adferiad Recovery is a recently-formed Welsh charity, the result of a merger between Hafal, CAIS and WCADA on April 1st 2021. Adferiad Recovery is a charity and company limited by guarantee which speaks for people with a serious mental illness (including schizophrenia, bipolar disorder, and other conditions involving psychosis or loss of insight), people affected by addiction, and people with co-occurring diagnoses, and for their families and carers, as well as for a wider group of vulnerable people for whom we provide services.

Adferiad Recovery is governed by its members who elect our Board of Trustees (which has strong representation of service users and carers). Adferiad Recovery delivers services in all twenty-two counties of Wales and in Lancashire.

Because Adferiad Recovery is a specialist in supporting those with the highest needs our membership includes many people with direct experience of the Mental health Act – patients, families, and carers.

Adferiad Recovery works closely with Jo Roberts and supports her views on reform of mental health law as expressed here.

### **The current Mental Health Act**

The Mental Health Act casts a shadow over the whole subject of mental health, affecting how people with mental health challenges are perceived and treated even if their problems are quite low level.

The Act confuses criminal behaviour with serious illness and prescribes the same harsh treatment – compulsion, detention, distrust and disrespect.

The Mental Health Act is one of the main causes of the stigma associated with mental health precisely because its sole focus is on coercion. The public is well aware of the Act – they may not be able to name it, but most people have heard the language of “sectioning” and of “men in white coats” coming to take people away. This perception of the law is often lurid and inaccurate – but it reflects a sad truth: the Mental Health Act is indeed old-fashioned, one-sided, and unfair.

So, fixing the law on mental health is a wider issue than just reforming the rules on who can be detained. It is about a fundamental shift away from coercion and towards respect and dignity.

Patients’ and families’ support for compulsion is not unconditional. It is based on the expectation of a trade-off where we recognise the need for compulsion if the government reciprocates with compensatory legal rights – not just safeguards but active rights which kick in before compulsion becomes necessary.

### **The Independent Review and the draft Bill**

At the heart of the Independent Review there was an assumption that the Mental Health Act is essentially not too far wrong: it has been refined over the years and so we are running out of ways of improving it. The Chairman of the Independent Review Sir Simon Wessely put it bluntly before he even started his review: “In my experience it is unusual for a detention to be unnecessary – by the time we get to that stage people are often very unwell, and there seems few other alternatives available”.

But Sir Simon also pointed out that detentions have gone up nearly 50% in the last decade.

I do not think the proposed amendments to the law, though welcome, will make a big difference to the numbers detained; they do improve or introduce welcome safeguards and they might make a difference to patients' experience of detention and their path back to freedom – but not that much difference.

I do think that there are more significant reforms which could be made to the law which maintain safety for all but reduce use of compulsion and respect patients' rights.

### **Reciprocal rights**

We are not even close to achieving the optimal legal framework. All respect to the Independent Review because they did what was asked of them in seeing how the Act could be reformed; some respect too for the UK Government in listening and acting on that advice.

But what is missing is a new set of statutory rights aimed at *greatly reducing the use of compulsion*. I mean...

- Enshrine the principle of reciprocal rights in law to balance and compensate for compulsion
- Under this principle introduce rights to assessment, care and treatment applicable before/after/outside the context of the process of compulsion
- Introduce rights to care and treatment before people become so ill that detention is required: that means in practice a right to a holistic care plan *which services have a legal duty to deliver* (that is, not just that a plan is written, as in current Welsh law).
- Accord this right to anybody requiring specialist mental health services (i.e. above primary care level)
- A minimum, guaranteed choice of treatments available to all patients subject to compulsion – including psychological therapies
- A right to a choice of hospital – for example whether to go to a local hospital or travel further to a specialist unit backed up by the option for patients to use a personal budget to purchase their choice of care and treatment (see below)
- Statutory minimum “hotel” standards – including *en suite* private accommodation and gender separation where patients choose this – and access to leisure and educational opportunities and to modern outside communication facilities.
- Where patients lack capacity there should be an independent “guardian team” – the proposed Nominated Person supported by advocates (and legal experts where needed) who are wholly independent of mental health services and can act formally for the patient at all stages. Where the patient has capacity a similar team should be available to advise the patient
- Where the threshold where compulsion may be required is assessed to have been reached by mental health services the patient – or their guardian team – should be supported to identify and agree sufficient actions (not confined to the option of in-patient care) to reduce the risk below the threshold; where a patient or guardian

team cannot agree arrangements with mental health services then a tribunal should arbitrate

- In addition to the current CTO arrangements there should be a legal right for the patient (or guardian team) to insist on alternative, community-based arrangements subject to a test of safety
- All patients subject to compulsion (or their guardian team) should have the option to access a personal health budget (based on the cost of in-patient care) with which to design and purchase their own treatment and care package at an independent hospital or in the community - subject to the package meeting the threshold for reducing risk

Reciprocal rights were first raised by the Expert Committee chaired by Professor Geneva Richardson in 1999. At the time the Government was reluctant to take this forward because they felt that placing statutory requirements on health services to provide specific services was not the normal practice in the UK. But we said then and say again now: providing treatment and care through compulsion is also not normal – and the special case for statutory, reciprocal rights is therefore made.

Justice alone demands that reciprocal rights are provided. *But additionally legal rights to care and treatment would prevent the need for compulsion in many cases.*

### **Reducing use of compulsion through formal targets**

Compulsion is sometimes necessary but always frightening, expensive, and counterproductive in terms of mental health. The most valuable change for all concerned would be to reduce the use of compulsion safely.

As above this can be achieved in part by introducing rights to care and treatment before compulsion becomes necessary and by improving services so that more patients choose voluntary care and treatment.

But additionally services could be held to account more directly for reducing the use of compulsion through:

- Creating a legal duty on health and social services to establish and work towards ambitious targets to reduce use of compulsion
- Require “compulsion reduction plans” which set out how this will be achieved, including how services will...
- Provide care and treatment earlier before a crisis occurs
- Work harder to agree voluntary treatment with patients through negotiation
- Achieve earlier discharge safely by providing improved ongoing support in the community

### **Reform of criminal justice**

The UK has a cruel and draconian approach to criminal law and mental illness which has no place in the modern world. Indeed in some respects the Victorians had a more thoughtful view, recognising that the public had to be protected but that compassion was needed for those who were so ill that they had no control over their actions.

There is no convincing resolution offered in the draft Bill to the injustice of how the criminal law treats people with a serious mental illness. It is barbaric that people who are very seriously ill are treated as criminals. Other civilised countries understand that we should distinguish clearly between crimes committed purposefully and harm caused unwittingly by people whose illness has overwhelmed their judgement. Other countries have compassion for those who are so ill that they cannot take responsibility for their actions: we should be able to address this while still keeping everybody safe

The White Paper demonstrates that the UK Government recognises this problem and it includes practical proposals which would improve the pathway for these patients.

But we need to have a wider look at this. I am convinced that the time is right for a radical review of the law which leads to a system where safety is ensured (and, yes, this means detention where unavoidable) but patients are not punished for actions which are not the result of deliberate wrongdoing but rather of serious mental illness.

But there is no need to increase risk: detention as a means of protecting the public is not compromised by a no blame approach.

### **Carers, families, and the Nominated Person**

Carers and families often know best what to do when a patient is seriously ill – and they can help practically too. Carers and families – or the Nominated Person if different - should be part of the team which works with the patient to determine the best treatment and care.

I welcome introduction of the nominated person in place of nearest relative. However, the law could be strengthened to give the nominated person and carers a much greater role, specifically:

- Where patients lack capacity the nominated person or carers and families should typically lead the guardian team acting for the patient.
- Support for carers and families should form part of the package of support for the patient before, during, and after compulsion is used.
- Where the patient does not wish carers and family to be involved services should nevertheless always take note of carers' and families' evidence and views – this need not involve any breach of the patient's confidentiality.
- The safety of carers and families must be always be a specific consideration along with that of the patient and of other people.

### **Black people**

I am not convinced that the UK Government's proposals will lead to significant change in the experience of BAME patients and families.

The glaring injustice is the specific experience of Black people. There is no doubt that Black people in particular get a really bad deal – not just a “similar but less good” service but a completely different, negative experience which is often frightening and anti-therapeutic.

The gulf between services and the Black community requires radical action. Not just a public relations exercise but a revolution in services which learns from the past but decisively leaves it behind. We need to see a service created for Black patients which reflects their community in staffing, management, and culture and which is based on support and therapy with a focus on recovery rather than compulsion.

In the context of Wales the relatively small numbers involved (reflecting the population of Wales) should be seen as an opportunity rather than as a statistical problem: for example, it should be possible to speak to a significant proportion of those affected – surely the best approach.

An obvious place to start would be the experience of Black people in Wales. A total of 26 Black people were detained in Wales in the year ending September 2021 under Section 135 and 136 of the Mental Health Act (link below), on the face of it over twice the average rate. Research into those individuals' experience, including speaking to them and to their families, could enlighten services about those with the most serious problems and lead the way in improving the wider experience of Black people in mental health services in Wales.

Based on that dialogue we might:

- Develop a new service model for Black people which reflects their community in terms of staffing, management, and culture
- Transform the experience of Black patients with recovery-based support in place of routine compulsion

### **And in respect of Wales...**

In the event that the Welsh Government does not develop its own proposals I would support the adoption in Wales of the draft Bill subject to the necessary adaptations in respect of Welsh law and structures.

However, this would be a great disappointment and a failure of the Welsh Government to grasp the opportunity to introduce legislation within devolved powers, in particular building on the Mental Health Measure.

I would commend the ideas I have set out above to the Welsh Government but would also suggest that as starting point they might consider strengthening the right to a Care and Treatment Plan, improve the way they work, include how a person's current and future needs will be met, and specifically develop a duty for services to deliver on Plans. People must be given more choice and power over the treatments they receive.

**Further evidence**

I and my colleagues at Adferiad Recovery are happy to provide further evidence to the Committee in writing or in person.

*16 September 2022*