

Written evidence submitted by Dr Nahed Arafat, Interpreter and academic professional, and Dr Jane Woodin, Intercultural Communication Programme Lead, University of Sheffield (MHB0066)

We (Nahed Arafat ([\(10\) nahed arafat | LinkedIn](#)) /nahedarafat077@gmail.com and Jane Woodin (J.Woodin@sheffield.ac.uk) would like to make the following comments on the Mental Health Act Bill

Evidence for our responses come from both Research and pilot training activities:

- 1) Thesis published by Arafat (2018)- The influence of language and culture on Improving Access to Psychological Therapy (IAPT) for Pakistani, Somali and Yemeni patients in Sheffield: spiritual beliefs and emotions
<http://etheses.whiterose.ac.uk/24708/>
- 2) Knowledge Exchange Project (2022) carried out at the University of Sheffield, Developing Intercultural Training Approaches for Mental Health Professionals (Arafat; Woodin)
- 3) Other publications
 - a.) One size does not fit all: key messages from Pakistani, Somali and Yemeni (PSY) patients in Sheffield, UK, regarding the language and cultural challenges of the IAPT programme, 2021, <https://doi.org/10.1177/1757913921101150>
 - b.) Language, culture and mental health: a study exploring the role of the transcultural mental health worker in Sheffield, UK, 2015, <https://doi.org/10.1080/17542863.2015.1112419>

Our Evidence responds in particular to the following key questions:

How the changes made by the draft Bill will work in practice, particularly alongside other pieces of legislation including the Mental Capacity Act? Might there be unintended consequences and, if so, how should those risks be mitigated?

Some of the unintended consequences could be the non-understanding of this new legislation and what it means for the patients/services users (Arafat, 2018:284-285). Accessing information in English for people who are either illiterate or have only basic English skills might hinder their abilities to seek further clarification or communicate properly to get their point across (Arafat, 2018:257-259). Despite the use of interpreters, patients who are unwell often experience difficulty absorbing all the information. The provision of interpreters can be valuable, but for some people it can restrict them from opening up, and their presence can be an added challenge (Arafat, 2018:266-267, Arafat, 2021:267). Communication difficulties, cultural conflicts (such as the fear of stigma,

confidentiality, differences in backgrounds, etc.) and time constraints can pose a challenge (Arafat, 2016:7-8 and 11-12). Finally, some service users' families may not wish someone outside of their family to be their nominated person (NP) even though it might be the wishes of the service user; this can act as a barrier to the implementation of such changes in practice (Arafat, 2018:285).

In order to mitigate these risks, it is important to work with interpreters who are well trained and fully understand the mental health act and the changes. Culturally competent mental health workers who are proficient in the language can work closely with both patients and their families to ensure both understand their rights and their needs. Employing such workers is highly recommended because they can help patients address other communication issues such as hearing and learning disabilities, which can form an additional barrier (Arafat, 2016: 14-15). The provision of appropriate support to the patients when their families stand against their decisions is also recommended.

Does the draft Bill strike the right balance between increasing patient autonomy and ensuring the safety of patients and others? How is that balance likely to be applied in practice?

Although this Bill may strike a balance between increasing patient autonomy and ensuring the safety of patients and others, in practice, this balance can be difficult to achieve for several reasons: a) patients may still not fully understand their rights or may not be able to choose their own nominated person because of their mental state at the time of detention; b) patient's family may not approve of the nominated person as it may take their power away; c) to ensure the approach is effective in practice, workers, patients and their families as well as community organisation need to undergo a culture change (Arafat, 2018:285); a shift from trying to 'solve the problems' to 'taking a joint responsibility for understanding the issues' - before any problems can be 'solved' .

To what extent will the draft Bill reduce inequalities in people's experiences of the Mental Health Act, especially those experienced by ethnic minority communities and in particular of black African and Caribbean heritage? What more could it do?

Through patient participation in decision-making about their treatment, the draft Bill aims to improve the voice and experience of patients, but it does not take into account that many patients may not understand key information or be able to make the right decisions when they are assessed or admitted to hospital. In the Bill, it is stated that if a patient refuses the chosen treatment, it can still be administered against their consent if a second opinion is

obtained from a clinician. Often, this involves detention and forced treatment, in which cases patients may not be treated with dignity and respect.

Example from Arafat in her role as a transcultural mental health worker:

I encountered a distressing situation for a Muslim female patient who was detained after her husband claimed that she tried to kill him and posed a risk to his life. When I arrived at the hospital to see her, she was clutching a bag. According to the nursing staff at the hospital, she told them that she had cashed £2000 from the bank as requested by her husband, but they were not sure if she was telling the truth as she was not in her full senses at the time of admission to hospital and she could have made this up. To prevent theft, they tried to take the money from her to put in the safe, but she refused to give it to them. As I had a good understanding of the patient's cultural background and her language, the staff asked me to convince her to hand over the money. My trials went all in vain. Because the patient trusted her cousin, I called him and asked him to speak with her and convince her to hand over the money to the staff, but she said she would only do so when he arrives at the hospital. The cousin asked me to inform the staff that he would be at the hospital by 7:30 pm because he was working and could not leave his work earlier. As it was 6:00 pm, I was unable to stay any longer. In spite of my efforts to convince the staff to wait until the cousin arrives, they said they could not wait and would restrain the patient and take the money by force. In an instant, the doors of the ward were closed, patients were sent to their rooms, and four nurses (2 males and 2 females) restrained her. It was humiliating to the patient who was wearing a scarf and trying to cover herself and maintain her modesty during this; she also had to handle the situation on her own. Trying to regain her composure, she cried and raged, accusing me of not protecting her dignity as a Muslim. As I tried to defend myself, she was sobbing and angry at me. As I reflect on the incident, I believe the staff could have waited for this short period of time as they tried since morning to avoid this forced treatment that was quite humiliating to the patient. By enabling patients to understand why compulsory treatment and detention is considered appropriate, they can better challenge inequalities or disparities in treatment.

Patients can benefit greatly from replacing their nearest relative with a nominated person (NP), however, it can also pose potential challenges between relatives and the health care system (e.g. problems that relate to cultural or spiritual beliefs).

Although the draft Bill confirms the importance of early intervention and ensuring that individuals receive appropriate care, it is not addressing full solutions to these issues. Many BME patients are still unable to access treatment earlier due to language barriers (Arafat, 2021:266). Patients from BME backgrounds who are suffering from mental illness are often unaware of services that are available to them or how to access information about them. In addition, GPs often assume that BME patients prefer medication over therapy (Arafat,

2018). This means that they are not always given the option of therapy and individual needs are ignored. All these issues could have damaging consequences or pose risks to patients' emotional wellbeing and health.

The draft Bill considers advanced decision making and treatment as possible ways to help patients to express their wishes and preferences. However, if there is no change in the cultural approach or understanding by the health and social care professionals towards BME patients, how will they support them in expressing their wishes and beliefs? (Arafat, 2021, 267).

BME patients, and particularly black African and Caribbean heritage patients, are assumed to be too dangerous, which gives police more reason to hold powers against them. Because of this, they may end-up being mistreated, causing them to become quite threatening and abusive according to the health professionals. While taking these concerns into account, the draft Bill simply seeks to strengthen the patient's voice by tailoring treatment to their individual needs. More must be done to respect the views of and give thought to the concerns of patients. Numerous research studies have demonstrated how differently BME patients are treated, but no real action has been taken to address this (Arafat, 2021: 267).

Finally, while allowing AMHPs more time to do the assessment is beneficial, it is unrealistic to predict how much additional work they will have to do given that every patient has different needs and some situations are extremely complex. Some patients may require two hours while others may need the entire day particularly with the attendance of interpreters.

What more it could do:

Additional professional support (estimated at 70) may not be sufficient to build an inclusive ongoing mental health support system which can respond to all needs. Offering additional time for some service users who have particularly complex needs and/or need additional time does not always need to be undertaken by clinicians, already with a heavy caseloads and under considerable pressure. As part of the culture change we are proposing, addressing the needs (including spending time to understand them- from the patients' perspective-) could be undertaken by a range of people- thus supporting clinicians with appropriate pre-clinical interventions, not simply focusing on form-filling or even on interpretation, but on understanding the service user as a person.

What may still be missing is space for patients/service users to be heard and understood- in their own right- rather than simply with a view to removing them from the system. We would propose a shift in emphasis to one which allows for periods of joint responsibility, dialogue, negotiation and mutual listening and understanding. We draw on the following pilot project as evidence (full report here) [Final report 2.docx](#)

Report on Intercultural Communication Training Workshop: Summary

Intercultural communication training workshop project X/014405-18 – FCA-DH was carried out over a period of 8 months by Dr Nahed Arafat (Research Assistant) in collaboration with Dr Jane Woodin (School of Languages and Cultures) and Professor Brendan Stone (School of English), all University of Sheffield.

Key stakeholders in the project involved:

- 20 professionals from mental health professionals and Voluntary sector, Sheffield Health and Social Care took part in the project -
- 14 professionals took part in the survey and 6 people from these sectors took part in the interviews
- Pilot intercultural training workshop delivered to X people representing a range of MH backgrounds (including a range of authentic case studies) .

Recommendations were:

- Make the current training a full-day session to allow health and social care professionals to discuss the topics in greater depth.
- Give examples of how to work systematically with families from various backgrounds to improve patients' engagement with the services.
- Include case studies of traveller communities, refugees, and immigrants and how to engage with people who do not have fixed locations.
- Invite service users to the training session in order to facilitate health and social care professionals' understanding of and discussion of their perspectives.
- Take into consideration the different learning styles/needs (e.g. dyslexia) of learners.
- Challenge wider structural issues that lead to discriminatory mental health practices.

For this reason we propose that amendments to the bill- if it seeks to be really inclusive- allows space for conversation and discussion about the role and needs of mental health within the health service, and not seek only to respond in terms of time and numbers allocated to certain activities, but allow managers some degree of flexibility over how the time is used.

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