

# Review of the Mental Health Act 1983

The Royal College of  
Psychiatrists' submission of  
evidence

February 2018

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## About

The Royal College of Psychiatrists (RCPsych) exists to improve the outcomes of people with mental illness, and the mental health of individuals, their families and communities.

1. We are the professional medical body responsible for supporting over 18,000 psychiatrists in the UK and internationally.
2. We set standards and promote excellence in psychiatry and mental healthcare.
3. We lead, represent and support psychiatrists.
4. We aim to improve the outcomes of people with mental illness, and the mental health of individuals, their families and communities. We do this by working with patients, carers and other organisations interested in delivering high quality mental health services.
5. We represent the expertise of the psychiatric profession to governments and other agencies.

This submission has been developed following engagement with College members and faculties and consideration by the College's Council. As requested by the Review's Call for Evidence, it provides our view on the areas set out in its [terms of reference](#), which are set out first in this document (community treatment orders, nearest relative, advance decisions and care planning, safeguards: advocacy, safeguards: tribunals, and reforms to Part III). The submission also sets out our views around child and adolescent psychiatry and intellectual disability which have been highlighted by College members and faculties.

## Introduction

The Mental Health Act (the MHA) legislates for the non-consensual medical treatment of mentally disordered people who present significant risks to themselves or others. Its operation has, and any changes to it will have, very important consequences for people with mental illness and for professionals who work to support them. It is used over 50,000 times a year in England and Wales, and the majority of patients, carers and practitioners<sup>1 2</sup> support its use in accordance with the MHA's strict criteria.

RCPsych welcomes the Review of the Mental Health Act (the Review) as an opportunity to ensure the MHA provides a modern legislative framework for the medical treatment of people with mental illness. Improving patient care and the support given to patients, their families and their carers, in the least restrictive setting possible, must underpin any recommendations for its reform. Patients should be supported to help prevent them reaching crisis point, and if they are in crisis, it must be ensured that patients receive the highest standards of care, with adequate provision of community and early intervention services.

We are concerned about the rising numbers of formal admissions and the disproportionate number of detentions of people from ethnic minorities. The Review needs to fully consider the complex and entrenched causes of this, beyond legislation, including service provision, accessibility, societal injustices and ingrained inequalities.

Our members' survey (conducted in September 2017 published in January 2018) highlighted that the difficulty in accessing community mental health services is a key contributory factor behind rising numbers of detentions under the MHA. Specific consideration should also be given

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<sup>1</sup> The Mental Health Alliance (2017) A Mental Health Act fit for tomorrow An agenda for reform. Available at: [http://www.mentalhealthalliance.org.uk/news/A\\_Mental\\_Health\\_Act\\_Fit\\_For\\_Tomorrow.pdf](http://www.mentalhealthalliance.org.uk/news/A_Mental_Health_Act_Fit_For_Tomorrow.pdf)

<sup>2</sup> The Royal College of Psychiatrists (2018) Member Survey on the Mental Health Act. Available at: <http://www.rcpsych.ac.uk/policyandparliamentary/independentreviewofthemha/rcpsychmembersurveyonmha.aspx>

to the barriers preventing too many people in the black and minority ethnic (BME) community getting the support they need.

The Review is an important opportunity for mental health law to be amended to make sure an individual's dignity, autonomy and human rights are protected when subject to the MHA. Compatibility with international obligations must be taken into account along with the need to improve opportunities for patients to be involved in their care, along with their family, friends and carers.

The Review might consider if there are principles that should govern the minimum standards of care and treatment available to all mentally ill people, whether they are subject to the MHA or not. This is key to making recommendations that will inform the government's creation of 'a forward-looking plan of changes to legislation and practice, resulting in an enduring legacy of mental health support.'

**The College calls for a reformed MHA to be underpinned by principles including:**

- Patient benefit
- Non-discrimination
- Respect for diversity
- Respect for personal autonomy
- Informal care where possible
- Reciprocity
- Least restrictive alternative
- Patient participation
- Consensual care where possible
- Respect for carers.

It will be important for the Review to consider the interface with the Mental Capacity Act. This is underpinned by very different criteria to the MHA, but causes considerable confusion when many patients meet the criteria for both.

Consideration should also be given to including, within the MHA, a right to assessment of need and to requiring the provision of services to meet identified needs. This reflects that a range of professional staff, hospitals,

and other resources are needed to deliver appropriate care and treatment, in a timely manner, to people with mental illness.

These issues are set out in more detail in the following sections, along with our proposals for changes. The College looks forward to continuing to work with the Review on any specific details of implementation.

## Overview of principles to be considered throughout the Review

### **1. The law should support modern principles and practice of care and treatment for mental health patients.**

This includes the principles of patient choice and participation, human rights and equality, and evolving ways of working for psychiatrists and other mental health professionals. Reformed mental health legislation should not:

- have an adverse effect on voluntary patients by making them fear seeking support
- have an adverse effect on the safeguards for patients under the MHA because staff requirements cannot be met
- require practitioners to have to balance the ethical principles of their profession against compliance with the law.

### **2. The Review should seek to reduce stigma and discrimination against people with mental illness. Wherever appropriate the principles governing mental healthcare should be the same as those which govern physical health.**

Despite awareness and acceptance of mental illness having risen since the MHA was reviewed, stigma and discrimination remain a regular experience for people with mental illness and a deterrent against seeking help. Legislation cannot cure social problems that are rooted in prejudice, but any law with a discriminatory impact clearly legitimises and contributes to stigma. Legislative reform can only play a small part in improving patient care. The following are important factors in improving mental health:

- Reduced stigma and discrimination
- Improved equality in accessing and receiving support

- Enhanced awareness within society
- An adequate and well-trained workforce
- Access to a range of psychological and medical treatments
- Co-production: patient involvement in care decisions and planning.

**3. Patients must always get the care appropriate to their needs with informal treatment, care and support preferred over compulsion.**

Compulsory powers should only be exercised as a last resort.

## **Summary: areas RCPsych recommend the Review consider**

### **Community Treatment Orders (CTOs)**

CTOs should be retained within the MHA, with modifications.

- The Review should, as an overall aim, focus on amending rather than abolishing CTOs as they can provide an essential therapeutic benefit when used correctly.
- The remit of CTOs should be limited to ensure they are only used when most beneficial. The Review should consider amending the criteria to reflect a history of non-compliance with treatment leading to subsequent compulsory admission(s) within a defined timeframe.
- Where appropriate, Advance Care Plans should be used as an alternative to CTOs in patients where this is likely to be effective, and joint care planning should be incorporated into CTOs as much as possible.

### **Nearest Relative**

The current 'nearest relative' system should be replaced with a system where patients chose a 'nominated person'.

Safeguards need to be put in place to ensure:

- family members are still involved
- there is a protocol for deciding a nominated person for children
- there is a protocol for deciding a patient's nominated person when they are unable to choose one themselves
- inappropriate people do not fill the role
- the rights of the nominated person are reviewed.

### **Advance Care Planning**

Advance care planning should be used more in practice.

The College calls on the Review to consider:

- strengthening the use of advance care planning/advance preferences, including through improved recording of, and access to, Advance Care Plans and clarity in creating and phrasing them
- improving cultural consideration within care planning
- practical support in forming Advance Care Plans.

### **Safeguards: Advocacy**

Advocates should be available to all patients in psychiatric inpatient settings, as in Wales, as well as patients on a CTO.

The Review should also consider:

- taking action to ensure patients are aware of, and are able to, benefit from their right to an advocate
- streamlining referrals to advocacy services given inconsistency in access
- protecting equalities through advocacy
- appropriate training for advocates.

### **Safeguards: Tribunals and Statutory Second Opinions**

Mental Health Tribunals should continue to comprise a legal chairman, medical member and a specialist member.

- The Review should also consider:
- recommending steps to ensure tribunal panels are reflective of the communities they work with
- abolishing hospital managers' appeals
- the remit of tribunals
- improving the recruitment and availability of SOADs.

### **Reforms to Part III**

Legislative reforms should be considered for Part III of the MHA.

- Mental Health Tribunals should be empowered to allow a patient's transfer to a lower level of hospital security.
- A legislative solution should be found to tackle the 'double jeopardy' of prisoner-patients who have an indeterminate or fixed sentence being required to have both a Mental Health Tribunal and Parole Board hearing before conditional discharge to the community.
- Section 45A (the hybrid order) of the MHA should be abolished.
- The system of the Ministry of Justice (MoJ) approval of section 17 leave of absence from hospital should be improved.

### **Child and Adolescent Psychiatry**

There should be clarification of the:

- scope of parental responsibility
- interface between Police Protection Orders (PPOs) and section 136 of the MHA in relation to children and young people
- interface between section 25 of the Children Act 1989 and sections 2 and 3 MHA 1983.

### **Intellectual Disability**

'Learning disability' should remain within the remit of the MHA, referred to as 'intellectual disability', with the criteria for 'abnormally aggressive or seriously irresponsible /conduct' reviewed. The Deprivation of Liberty Safeguards (DoLS) process and Mental Capacity Act should be strengthened in relation to aggressive patients deemed unable to make treatment decisions.

## Community Treatment Orders (CTOs)

**Recommendation: CTOs should be retained within the MHA, with modifications.**

- The Review should, as an overall aim, focus on amending rather than abolishing CTOs as they can provide an essential therapeutic benefit when used correctly.
- The remit of CTOs should be limited to make sure that they are only used when most beneficial. The Review should consider amending the criteria to reflect a history of non-compliance with treatment leading to subsequent compulsory admission(s) within a defined timeframe.
- Where appropriate, Advance Care Plans should be used as an alternative to CTOs in patients where this is likely to be effective, and joint care planning should be incorporated into CTOs as much as possible.

Patients, carers and practitioners recognise the need for the option to apply some conditions to some patient discharges to keep people safe and well.<sup>3</sup> The College also recognises that there are widespread concerns about CTOs, such as:

- they do not reduce readmissions;
- they can impede the therapeutic relationship between patient and doctor;
- they can be misused and/or overused.

The use of CTOs needs to be reformed to address these concerns, while also protecting those aspects that fit into a care plan that keep patients safe and well and out of the criminal justice system. The College has

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<sup>3</sup> The Mental Health Alliance (2017)

considered the use of CTOs in a 2015 report<sup>4</sup> and we recommend this be evaluated by the Review.

## Background and key issues

- The number of people on CTOs has increased in recent years, from 4,291 in 2010/11 to 5,426 in 2015/16.<sup>5 6</sup> This needs to be considered in the context of the fall in inpatient beds, the rise in detentions under the MHA, and the scarcity of resources for community mental health services. Tackling these underlying factors will be essential in reducing the number of people on CTOs. Specific factors linked to the rise in CTO require consideration, including their wide remit and ‘the lobster pot effect’. The latter occurs where a patient remains on a CTO regardless of the outcomes, because it is either interpreted that they are doing well within the CTO framework, or not recovering sufficiently and the CTO remains necessary.
- Use is highest for ‘Black or Black British’ people (60.1 uses per 100,000 population),<sup>7</sup> almost nine times the rate for white people (6.8 uses per 100,000 population). There are also high rates of patients being recalled from CTOs among African Caribbean (9.2 %) and Asian Pakistani (7.9 %) groups.<sup>8</sup> While there may be specific factors that affect this, there are wider factors related to societal injustices and ingrained inequalities which will require a broad and coordinated response across government.
- There are three randomised controlled trials (RCTs) and two meta-analyses that suggest that CTOs have little to no effect on the rates of

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<sup>4</sup> The Royal College of Psychiatrists (2015). Occasional Paper: Thinking about community treatment orders: a structured clinical approach to decision-making (OP99). Available at: <http://www.rcpsych.ac.uk/files/pdfversion/OP99.pdf>

<sup>5</sup> Inpatients Formally Detained in Hospitals Under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment - England, 2010-2011, Annual figures. Available at: <https://digital.nhs.uk/catalogue/PUB00898>

<sup>6</sup> Supervised Community Treatment: 2015/16, Annual figures. Available at: <http://digital.nhs.uk/catalogue/PUB22571>

<sup>7</sup> NHS Digital, Mental Health Act Statistics, Annual Figures: 2016-17, Experimental statistics. Available at: <https://digital.nhs.uk/catalogue/PUB30105>

<sup>8</sup> Gajwani, R, Parsons, H, Birchwood, M, and Singh, SP. Ethnicity and detention: are Black and minority ethnic (BME) groups disproportionately detained under the Mental Health Act 2007?. *Soc Psychiatry Psychiatr Epidemiol.* 2016; 51: 703-711

readmissions, which is one of the outcome measures of CTOs.<sup>9 10 11 12 13</sup>

For example, the most recent UK study – the 2013 Oxford Community Treatment Order Evaluation Trial (OCTET) – found that after randomising patients to receive either a CTO or a short period of section 17 day-leave from hospital before discharge, the number of patients readmitted did not differ between groups, nor were there any other outcome differences. While the study focused only on patients with psychosis, it concluded that in well-coordinated mental health services, the imposition of compulsory supervision does not reduce the rate of readmission or sufficiently reduce overall hospital admission to justify the significant curtailment of patients' personal liberty. Further research is needed to consider what value CTOs have on admissions, care quality and patient safety before considering their abolition.

- Other outcome measures for CTOs, such as the management of risk, need to be considered but have not been extensively researched. Patients can be recalled when they require medical treatment in hospital for their mental disorder, and where there would be a risk of harm to the health or safety of the patient or other persons as a result of non-compliance with their treatment. CTOs can be a less restrictive option for the management of such cases as they allow patients to be treated out of hospital. There are concerns that a system that did not allow the swift recall of patients might mean that more people were kept in inpatient units for a greater length of time than necessary.

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<sup>9</sup> Burns T. et al, Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial, *Lancet*. 2013 May 11;381(9878):1627-33. doi: 10.1016/S0140-6736(13)60107-5. Epub 2013 Mar 26.

<sup>10</sup> Swartz MS, Swanson JW et al . Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals. *Am J Psychiatry* 1999; 156: 1968-75.

<sup>11</sup> Steadman HJ, Gounis K, Dennis D, Hopper K, Roche B, Swartz M, et al. Assessing the New York City involuntary outpatient commitment pilot program. *Psychiatr Serv* 2001; 52: 330-6.

<sup>12</sup> Kisely S, Hall K. An updated meta-analysis of randomized controlled evidence for the effectiveness of community treatment orders. *Can J Psychiatry* 2014; 59: 561-4.

<sup>13</sup> De Jong MH, Kamperman AM, Oorschot M, Priebe S, Bramer W, van de Sande R, Van Gool AR, Mulder CL. Interventions to Reduce Compulsory Psychiatric Admissions: A Systematic Review and Meta-analysis. *JAMA Psychiatry*. 2016;73(7):657-664.

- There are a number of broader ethical concerns around CTOs, that also apply more generally to the MHA, including that they were introduced primarily for public safety, rather than the benefit of patients, and that they can compromise clinicians and have an impact on therapeutic relationships.

### **RCPsych proposals – CTOs**

While there are concerns about the use of CTOs, the College does not believe they should be abolished as this would have detrimental consequences for patients. We propose the following amendments to CTOs for the Review to consider when drawing up its recommendations. These should be supported by further research on the concerns about their use and their role in allowing clinicians to manage risk in patients. The College has previously considered some of these areas in its 2015 paper, *Thinking about community treatment orders: a structured clinical approach to decision-making*, and we recommend this be evaluated by the Review.<sup>14</sup>

- Limiting the remit of CTOs – the MHA Code of Practice makes clear that CTOs are designed to be used on patients where there is an established link between their non-concordance with medication and them relapsing and having to return to hospital. The Code states: ‘A *tendency to fail to follow a treatment plan or to discontinue medication in the community, and then relapsing may suggest a risk justifying use of a CTO rather than discharge into community care.*’<sup>15</sup>

Although this is advised for the use of CTOs, it is not a legal criterion that there be a demonstrated pattern of relapse and recovery after

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<sup>14</sup> The Royal College of Psychiatrists (2015). Occasional Paper: Thinking about community treatment orders: a structured clinical approach to decision-making (OP99). Available at: <http://www.rcpsych.ac.uk/files/pdfversion/OP99.pdf>

<sup>15</sup> Department of Health. *Code of Practice Mental Health Act 1983*. London: TSO. 2015 (paragraph 29.13)

effective treatment in order for a CTO to be used (as is the case in other jurisdictions). Limiting the remit of CTOs by making an established history of relapse due to non-compliance with treatment a criterion of their use, could potentially improve some of the problems outlined previously.

- Care planning - CTOs exist as a form of care planning and go beyond a power of recall. Any amendments must take this into account and find ways to make sure that all patients are given adequate care plans, including ensuring the care planning is prioritised in the Code of Practice. A patient's preferences and views should always be considered, whatever their mental state. This may strengthen the CTO's conditions, better engage the patient in decisions and decrease the chance of readmission. For those patients able to do so, a system of advance care planning should be used as an alternative to CTOs, with patients playing a part in deciding how they are treated and how they are cared for. This needs to recognise that, under the MHA, some patients will be detained against their will, and that patients will be required to adhere to any discretionary conditions of a CTO in order to avoid the risk of recall to hospital.

## Nearest Relative

**Recommendation: The current 'nearest relative' system should be replaced with a system whereby the patient chooses a 'nominated person'.**

Safeguards need to be put in place to ensure:

- family members are still involved
- there is a protocol for deciding a nominated person for children
- there is a protocol for deciding a patient's nominated person when they are unable to choose one themselves
- inappropriate people do not fill the role
- the rights of the nominated person are reviewed

The rights of patients and carers, and how these rights interact, are an essential part of the MHA. RCPsych wants to make sure that the friends and families of patients are given as much involvement in care as possible, in a way with which patients are happiest. The current system for achieving this is outdated and does not meet the needs of patients, their families or carers. The College recommends that the existing nearest relative role be replaced with a nominated person role, supported by appropriate safeguards, to ensure the chosen individual is the most appropriate.

### Background and key issues

- Section 26 of the MHA stipulates who should be considered to be 'relatives' for the purposes of identifying a nearest relative, based on a hierarchical list of people assumed to have a relationship with a person detained under a civil section.<sup>16</sup> The nearest relative has a statutory and important role, including the right to:

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<sup>16</sup> Mental Health Act 1983, S.26. Available at: <https://www.legislation.gov.uk/ukpga/1983/20/section/26>

- be consulted about and object to an application for admission under section 3<sup>17</sup>
  - be informed about an application for section 2 detention (although not in relation to a CTO); order discharge from a section 2, section 3 and section 7
  - make an application for detention under section 2 or 3<sup>18</sup>
  - apply to the Tribunal on behalf of the patient under specific circumstances.<sup>19</sup>
- The nearest relative may be required to change under certain conditions (e.g. if they move abroad or because of a change in the patient's relationships). They may also change because the nearest relative delegates the role (subject to restrictions and disqualifications) or because the Approved Mental Health Professional (AMHP) believes that they are inappropriate and supports the (detained) patient to apply to the county court in order to displace them.
  - This current system is hierarchical, old-fashioned and assumes traditional family structures that have never been universal and are decreasingly commonplace.
  - It is also unreasonably onerous to expect patients to go to court to displace their nearest relative, especially as this could be at a time when the patient is at their most vulnerable. Attending court, alongside the accompanying procedures, is daunting for anyone, and may be even more challenging to deal with for a person with mental illness.

### **Proposals – Nearest Relative**

- Replacing the selection of a nearest relative with a 'nominated person' or 'named person' mechanism would allow the patient being

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<sup>17</sup> Section 11(4) the MHA

<sup>18</sup> Section 23(2) the MHA

<sup>19</sup> Section 33(2) the MHA

detained to specify a person who should fulfil the same role as that currently fulfilled by the nearest relative. This approach is supported by psychiatrists – in RCPsych’s recent survey of members, 62.4% of respondents believed a patient should be allowed to choose their nearest relative under the MHA.

- This would align with legislative provisions in other countries. For example, the Scottish Mental Health Act allows anyone aged 16 or over to choose their own named person as long as the witness can certify that the individual understands the effect of choosing a named person and that they have not been under any undue influence when making the decision. In Northern Ireland, the nominated person mechanism will form part of the Mental Capacity Act, once implemented.
- There are a range of necessary safeguards to support this alternative mechanism:

- Involving family members:

In cases where the nominated person is not the primary carer, there needs to be a way to make sure both are involved. Any system introduced should allow for family members to be involved alongside a nominated person, if they prove to be different people. This will be particularly important with young people and with patients with eating disorders, as there are understandable concerns about the possible exclusion of family members.

- Children and nominated persons:

A protocol for deciding who is old enough to choose a nominated person is needed. In Scotland, under 16s cannot choose a named person, instead their named person will be one of the following:

- A person, 16 years old or more, who has parental rights and responsibilities

- The local authority, if being looked after under a care order under the Children Act 1989
  - (In all other cases) the main carer of the patient, as long as they are at least 16 years old.
- When a patient cannot nominate a person:  
In circumstances where a detained patient is unable to express a preference, the current hierarchical list should be retained as a back-up (and updated to reflect societal change). Clarity is also needed on how to deem a person to be in a fit state to choose their nominated person.
- 'Inappropriate' nominated persons:  
In cases where patients nominate a person deemed to be inappropriate by the Responsible Clinician, there will need to be a protocol as to how to proceed.
- Rights of the nominated person:  
The current system provides the nearest relative with important rights, including the right to stop a patient being detained under section 3 or guardianship and to order discharge from section 2 or section 3, with some limitations. It is essential that the Review consider the implications of this right being extended to a nominated person chosen by the patient.

## Advance Care Planning

**Recommendation: Advance care planning should be used more in practice.**

The College calls on the Review to consider:

- strengthening the use of advance care planning/advance preferences, including through improved recording of, and access to, Advance Care Plans and clarity in creating and phrasing them
- improving cultural consideration within care planning
- practical support in forming Advance Care Plans.

It is important that patients are given every opportunity to discuss the management of their illness to make sure that the MHA supports people to make decisions about their care and treatment. An important mechanism to support this is advance care planning, which involves patients and their carers, families, friends and clinicians in a way that can reduce the stress typically caused by being detained under the MHA.

While the College supports the continuation of the MHA authorising treatment with medication which would otherwise be prevented by a legally binding advance directive - due to the risk that patients may not receive appropriate treatment - we believe a patient's wishes and any Advance Care Plans should be taken into account wherever possible. A common theme highlighted in responses to RCPsych's members' survey was that awareness of advance care planning should be increased among patients and clinicians, and that patients should be offered more support by their care team to produce Advance Care Plans.

### Background and key issues

- Advance care planning has a range of benefits including: empowering patients, improving engagement and therapeutic relationships, promoting responsibility in patients for the management of their

illness, promoting shared decision-making, and reducing coercion.<sup>20</sup>

A meta-analysis of randomised controlled trials on advance statements showed a statistically significant and clinically relevant 23% reduction in compulsory admissions in adult psychiatric patients.<sup>21</sup>

- Although some patients will find it harder than others to participate in advance care planning, encouraging patients to discuss what they have found helpful and unhelpful in the past can be very beneficial. This helps treating teams to make sure the care of formally admitted patients under the MHA is as therapeutic as possible.
- While the MHA Code of Practice acknowledges that clinicians should take into account the Advance Care Plans made by detained patients relating to their treatment, there is evidence that this process is not comprehensively used. The Care Quality Commission's (CQC) recent report on the MHA found no evidence of the patient being involved in their care planning in 29% of the patient records examined.<sup>22</sup>
- There are barriers <sup>23</sup> that contribute to the underuse of Advance Care Plans and need to be addressed:
  - Operational features of the environment, such as a lack of communication between staff, or poor access to the document (for example, one study found that only 20% of advance statements were accessed during a crisis <sup>24</sup>).
  - Clinical barriers (e.g. inappropriate treatment requests, a patient's desire to change their mind about treatment during crisis).
  - Complexity of forms.
  - Large case-loads and time pressures.

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<sup>20</sup> Jankovic, J., et al. (2010). 'Advance statements in adult mental health.' *Advances in Psychiatric Treatment* 16(6): 448-455.

<sup>21</sup> Interventions to Reduce Compulsory Psychiatric Admissions: A Systematic Review and Meta analysis. Mark H. de Jong; Astrid M. Kamperman; Margreet Oorschot,; et al; *JAMA Psychiatry*. 2016;73(7):657-664. doi:10.1001/jamapsychiatry.2016.0501

<sup>22</sup> CQC (2016) Monitoring the Mental Health Act in 2015/2016. Available at: <http://www.cqc.org.uk/publications/major-report/monitoring-mental-health-act-report>

<sup>23</sup> Jankovic, J., et al. (2010). 'Advance statements in adult mental health.' *Advances in Psychiatric Treatment* 16(6): 448-455.

<sup>24</sup> Srebnik DS, Russo J., Consistency of psychiatric crisis care with advance directive instructions. *Psychiatr Serv*. 2007 Sep;58(9):1157-63.

## Proposals – Advance care planning

- Strengthening the status quo – there are several ways advance care planning could be strengthened through legislation and changes to the MHA Code of Practice:
  - Clarify the MHA Code of Practice that states that clinicians should take into account ‘wishes expressed in advance’.
  - Include a right to have ‘past and present wishes’ taken into account by anyone providing care under the MHA, second opinion doctors and tribunals (as is the case in Scotland).
  - Consider the implications of the Law Commission report on mental capacity and DoLS<sup>25</sup> where patients, when they have capacity, consent to admission and restraint should they lose capacity in the future.
  - Encourage advance preferences, setting out patients’ preferred treatments, as part of a care plan.
  - Promote co-produced treatment plans agreed by the clinician and the patient, allowing input from family members (acknowledging that while others may advise, an advance decision is made by an individual patient and reflects that patient’s wishes).
- Improving recording and access – unless the patient or family informs services, clinicians have no way of knowing if an Advance Care Plan has been made. This is particularly problematic when the patient is too ill to express this, and the family/carer may not know whether one is in place or have access to it, especially in emergencies. There is potential to learn from:
  - the national system for recording and accessing Lasting Power of Attorney (LPA) statements;

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<sup>25</sup> Law Commission (2017) Mental Capacity and Deprivation of Liberty. Available at: [http://www.lawcom.gov.uk/app/uploads/2017/03/lc372\\_mental\\_capacity.pdf](http://www.lawcom.gov.uk/app/uploads/2017/03/lc372_mental_capacity.pdf)

- international practice (such as some US states where checking for advance plans is mandatory upon admission to hospital);
- and the arrangements in Scotland.

Scottish Health Boards are required to keep copies of any advance statements with patients' records and to inform the Mental Welfare Commission of their existence and location, which is held on a register. The Commission records any instance where treatment received by a patient conflicts with their advance statements, and the patient and their named person is notified in writing. In 2016/17, 55 instances were recorded, down from 66 the previous year.<sup>26</sup>

- **More practical support** - guidance on the wording of Advance Care Plans would be beneficial. It is difficult to write a clear and unambiguous statement suitable for decision-making but also broad enough to cover the wide range of scenarios where the Advance Care Plan might be considered.
- **Clarity on verbal Advance Care Plans** - Clinicians can be placed in difficult positions where a patient lacks capacity, but their family claims that the patient has made a verbal decision not to receive a given treatment.
- **Interaction with LPA** - there needs to be clarification on how LPAs interact with Advance Care Plans. Currently, if an LPA is made after an advance directive (AD) unless otherwise specified in the LPA, the LPA overrides it. If the AD is made after the LPA, it is not clear which should be followed.
- **Improved cultural consideration within care planning** - greater consideration is needed of cultural preferences when developing Advance Care Plans. For example, different ethnic groups have varying rates and experiences of mental illness, reflecting their

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<sup>26</sup> The Mental Welfare Commission Scotland (2017) Mental Health Act monitoring report 2016-17. Available at: [http://www.mwscot.org.uk/media/387603/mental\\_health\\_act\\_monitoring\\_report\\_2016-17.pdf](http://www.mwscot.org.uk/media/387603/mental_health_act_monitoring_report_2016-17.pdf)

respective cultural and socio-economic contexts and their need for access to culturally appropriate treatments. People with a learning disability may want to be treated on a general adult ward.

Transgender and gender diverse people could express whether they should be detained on a male or female ward.

## Safeguards: Advocacy

**Recommendation: Advocates should be available to all patients in psychiatric inpatient settings, as in Wales, as well as patients on a CTO.**

The Review should also consider:

- taking action to ensure patients are aware of, and are able to benefit from, their right to an advocate
- streamlining referrals to advocacy services given inconsistency in access
- protecting equalities through advocacy
- appropriate training for advocates.

Independent Mental Health Advocacy (IMHA) services benefit patients by giving them a stronger voice in their care and treatment.<sup>27</sup> They provide an important and welcome safeguard for patients experiencing detention and compulsion which typically disempowers them. In practice, however, the potential benefit of advocacy is constrained by varied levels of access and uptake. The narrow conception of statutory advocacy as safeguarding rights should be broadened to one that emphasises self-determination and participation in decisions about care and treatment.

### Background and key issues

- Those who qualify for IMHA in England are primarily: detained patients; formal community patients on a CTO or subject to guardianship; or patients on conditional discharge under the 1983 Act. Patients who are in hospital voluntarily (and who are often as unwell as those detained under section) are not given the same level of

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<sup>27</sup>Wetherell R. Wetherell A. (2008) 'Advocacy: Does it really work?' In C. Kaye and M. Howlett (eds) *Mental Health Services Today and Tomorrow: Experiences of Providing and Receiving Care*. Abingdon: Oxford.

safeguarding. In Wales, patients are entitled to an IMHA not only if they are detained under the MHA but also if they are a voluntary patient.

- At present, each qualifying patient should be made aware of advocacy services by a responsible person. CQC data show that a significant minority of patients do not have their rights about IMHA properly explained or discussed with them at all. Research has found that ‘less than half of qualifying patients’ access IMHA services,<sup>28</sup> and variation in access to, and uptake and quality of, IMHAs.<sup>29 30</sup> This is particularly relevant for BME communities and older people.
- Access is influenced by availability of IMHA services, reflecting the quality of commissioning and the understanding of patients. It is also influenced by the understanding of mental health professionals and their attitude to advocacy.
- Current provisions do not specify the position of patients who lack capacity to make certain decisions (for example, to consent to providing access to their records). This could present problems because an advocate can access records only where the patient has capacity/is competent to consent, or if production would not conflict with a decision made by a donee or deputy of the Court of Protection.<sup>31</sup>

## **Proposals – Advocacy**

- **Extending advocacy provision – as the House of Commons’ Health Select Committee found, there is a compelling case to extend advocacy provision to cover all patients undergoing treatment on**

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<sup>28</sup> Newbigging K. et al. 'When you haven't got much of a voice': an evaluation of the quality of Independent Mental Health Advocate (IMHA) services in England, Health Soc Care Community. 2015 May;23(3):313-24. doi: 10.1111/hsc.12153. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/25475401>

<sup>29</sup> Newbigging K. et al., (2012) 'The right to be heard'. Available at: [https://www.uclan.ac.uk/research/explore/projects/assets/mental\\_health\\_wellbeing\\_review\\_of\\_independent\\_mental\\_health\\_advocate\\_research\\_report\\_190612.pdf](https://www.uclan.ac.uk/research/explore/projects/assets/mental_health_wellbeing_review_of_independent_mental_health_advocate_research_report_190612.pdf)

<sup>30</sup> Department of Health (2012) Post-legislative assessment of the Mental Health Act 2007. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/228522/8408.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228522/8408.pdf)

<sup>31</sup> CQC (2016) Monitoring the Mental Health Act in 2015/16. Available at: [http://www.cqc.org.uk/sites/default/files/20161122\\_mhareport1516\\_web.pdf](http://www.cqc.org.uk/sites/default/files/20161122_mhareport1516_web.pdf)

psychiatric wards or subject to CTOs.<sup>32</sup> The government previously turned down this recommendation on the grounds that a key role of IMHAs is knowledge of the MHA,<sup>33</sup> a decision RCPsych believes should be reconsidered.

- **Awareness** – action is needed to make sure patients are aware of, and able to benefit from, their right to IMHAs. This could include strengthening the information-giving process (section 132) and extending the CQC's current inspection process to focus on the availability, take-up and effectiveness (through patient satisfaction) of advocacy services, to encourage local areas to ensure good provision.
- **Streamlining referrals to advocacy services** – for 'compliant' patients (those lacking capacity to consent to admission and treatment but are not objecting to it), it is important to make sure that advocacy is involved at the earliest opportunity to make sure they are still listened to and their rights are safeguarded. Advocates and IMHAs need to be involved in care planning meetings, be made aware of treatment decisions, and be involved in safe discharge planning (especially where patients are discharged into placements).
- **Protecting equalities through advocacy** – people at risk of discrimination, and protected groups under the Equalities Act subject to the MHA, should have access to an advocate with specialist knowledge of legislation to advocate appropriately for them. Areas with higher rates of detention and/or bed occupancy of people from BME communities will need to look at ways of reaching out to those communities. This has resource implications and will also be an issue for other minority groups, which should be clarified through an

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<sup>32</sup> House of Commons Health Committee (2013) Post-legislative scrutiny of the Mental Health Act 2007 First Report of Session 2013–14. Available at:

<https://publications.parliament.uk/pa/cm201314/cmselect/cmhealth/584/584.pdf>

<sup>33</sup> Department of Health (2013) Post-legislative Scrutiny of the Mental Health Act 2007: Response to the Report of the Health Committee of the House of Commons. Available at:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/252876/33736\\_Cm\\_8735\\_Web\\_Accessible.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252876/33736_Cm_8735_Web_Accessible.pdf)

adequate equality analysis.<sup>34</sup> The MHA Code of Practice already states that local authorities should make sure IMHAs understand equality issues and that there are sufficient IMHAs with specialist understanding of the needs of particular groups. This could be strengthened through legislation, with local areas required to commission IMHA services that meet the needs of local communities and protected groups by conducting population needs assessments and equality impact assessments.

- **Appropriate training for advocates** – advocates must be appropriately trained to support a range of mental health conditions. For instance, when working with patients with eating disorders, very ill patients can remain highly articulate and so those unfamiliar with eating disorders may assume that they remain able to make decisions when in fact they do not.

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<sup>34</sup> Independent Mental Health Advocacy Project Team (2012) Consultation Response. IMHA project team response to Department of Health Consultation on Options for Funding Allocations for IMHA services. Available at: ([http://www.uclan.ac.uk/research/explore/projects/assets/mental\\_health\\_wellbeing\\_IMHA\\_team\\_response\\_to\\_DH\\_consultation\\_on\\_funding\\_options\\_september\\_2012.pdf](http://www.uclan.ac.uk/research/explore/projects/assets/mental_health_wellbeing_IMHA_team_response_to_DH_consultation_on_funding_options_september_2012.pdf))

## Safeguards: Tribunals and Statutory Second Opinions

**Recommendation: Mental health tribunals should continue to comprise a legal chairman, medical member and a specialist member.**

- The Review should also consider:
- recommending steps to ensure tribunal panels are reflective of the communities they work with
- abolishing hospital managers' appeals
- the remit of tribunals
- improving the recruitment and availability of SOADs.

The ability to apply to a mental health tribunal, independent from a detaining authority, is an important and necessary part of safeguarding for patients detained under the MHA in hospital for assessment and/or treatment of a mental disorder, or who are subject to compulsory powers in the community. The composition of a tribunal panel is therefore a key consideration, while focus is needed on how the tribunal operates.

### Background and key issues

- Tribunals are formal meetings where an independent panel looks at the decision to keep a patient subject to the MHA. It comprises three people including a judge (in charge of the hearing), a tribunal doctor who is a consultant psychiatrist, and a specialist lay member who has detailed knowledge of a relevant area such as social care.
- The Government proposed amendments to the composition of tribunals (in particular, First-Tier Tribunals for Mental Health) to comprise a single member, with non-legal members only being involved on a case-by-case basis.<sup>35</sup> The College advised that these

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<sup>35</sup> Ministry of Justice (2016), Transforming our Justice System. Available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/553261/joint-vision-statement.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/553261/joint-vision-statement.pdf)

proposals should not be implemented.<sup>36</sup> There is a strong need for the presence of a medical professional in any tribunal where medico-legal decisions are made, so it should never be presumed that only one person is sufficient to carry out the task of a tribunal panel. In response, the Government said it would not go ahead with its original proposal, but that the Senior President of Tribunals can make provision for tribunals to comprise one, two or three members 'as required, in order to determine the matters before the tribunal justly and fairly'.<sup>37</sup> This leaves the possibility that some tribunals will proceed with only one member.

- There are various challenges specifically associated with the way tribunals operate.
  - They are often subject to delays and it is common for patients to have little or no information about the length of the process.<sup>38</sup>
  - People can be deterred from appealing to tribunals due to a lack of awareness of the process and the requirement to appeal in writing.<sup>39</sup>
  - There are significant regional variations in referrals to MHA tribunals in relation to young people.
  - They do not reflect the fact that different ethnic groups have varying rates and experiences of mental illnesses due to their respective cultural and socio-economic contexts and access to culturally-appropriate treatments.

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<sup>36</sup> Royal College of Psychiatrists (2016) Consultation Response. Transforming our justice system: panel composition in tribunals. Available at: <https://www.rcpsych.ac.uk/pdf/RCPsych%20response%20Panel%20Composition%20in%20Tribunals%20consultation%20November%202016.pdf>

<sup>37</sup> Ministry of Justice (2017) Transforming our justice system: assisted digital strategy, automatic online conviction and statutory standard penalty, and panel composition in tribunals Government response. Available at: <https://consult.justice.gov.uk/digital-communications/panel-composition-in-tribunals/results/transforming-our-justice-system-government-response.pdf>

<sup>38</sup> CQC (2011) Patients' experiences of the first-tier tribunal (Mental Health). Available at: <http://www.cqc.org.uk/file/4807>

<sup>39</sup> Bradley C, et al. (1995). 'Why do so few patients appeal against detention under Section 2 of the Mental Health Act?' *BMJ (Clinical research ed.)* 310(6976): 364-367.

## Proposals – the Tribunal process and SOADs

- **Tribunal panel composition** – RCPsych strongly emphasises the importance of retaining a full (three-person) panel to safeguard patients’ rights. The Review should assess the implications of the Government’s changes to this system and make sure all tribunals have the necessary legal, medical and specialist lay expertise as standard.
- **Representativeness** – tribunal panels should reflect the communities they work with. People from BME groups tend to be under-represented in the judiciary when compared with the population as a whole. 10% (168) of tribunal judges are from BME groups.<sup>40</sup> The Review should also consider how to make sure people with protected characteristics under the Equalities Act are not discriminated against through use of the MHA, and have the power to direct alternatives (for treatment) where these rights are judged to have been infringed.
- **Hospital managers’ appeals** – the value of hospital managers’ appeals within the safeguarding process should be reviewed. While these provide another opportunity for patients to have their cases reviewed, their effectiveness is debated. College members have expressed concern that managers’ appeals ‘distract from frontline care’, are ‘meaningless’ and ‘falsely raise expectations’. They have been subject to little evaluation, and data on outcomes from appeals to hospital managers’ panels are not collected at a national level.
- **The remit of tribunals** – while regular reviews of patients under the MHA are essential, and must be present as a safeguard, changes to the remit of tribunals need to be considered. This needs to make sure the service is able to meet demand or undertake more regular reviews. It must also address the challenge of reviewing treatments. Due to the nature of their work, tribunal doctors often either do not

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<sup>40</sup> Courts and Tribunals Judiciary (2017) Judicial Diversity Statistics. Available at: <https://www.judiciary.gov.uk/about-the-judiciary/who-are-the-judiciary/diversity/judicial-diversity-statistics-2017/>

work full time or are retired, and will therefore have difficulty commenting on treatment based on a one-off interview and reports which may not provide sufficient detail. Currently, the detaining authority is responsible for scrutinising admissions through legal papers, a process which could be strengthened.

- **Recruitment and availability of SOAD services** – The Second Opinion Appointed Doctor (SOAD) service is an additional safeguard of patient rights. SOADs provide an independent medical opinion on whether certain treatments are appropriate, and whether due consideration has been given to the views and rights of a patient who refuses treatment or is unable to consent. There is a need to consider that delays in accessing SOAD assessments are common, and there are too few doctors available to the service. A 2014 study of SOAD assessments<sup>41</sup> found about half of inpatients were seen within 30 days, a quarter were seen within 60 days, and the remainder waited up to 150 days, and in some cases even longer. Requests for SOAD visits continue to rise but the number of doctors on the SOAD panel has been decreasing. The CQC cites three reasons for declining numbers:
  1. Restrictions on fees.
  2. The new consultant contract which gives employers more control over consultants' activities.
  3. Employers being more reluctant to allow consultants to perform duties outside of local targets and organisational performance.<sup>42</sup>

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<sup>41</sup> Murphy P, Ajaz P.A. (2014). 'Timeliness of second opinion appointed doctors' assessments of treatment plans for patients detained in medium security hospitals in London, UK.' *Criminal Behaviour and Mental Health* 24(3): 181-187.

<sup>42</sup> CQC (2016). Monitoring the Mental Health Act 2015/16. Available at: [http://www.cqc.org.uk/sites/default/files/20161122\\_mhareport1516\\_web.pdf](http://www.cqc.org.uk/sites/default/files/20161122_mhareport1516_web.pdf)

## Reforms to Part III

### **Recommendations: Legislative reforms should be considered for Part III of the MHA.**

1. Mental Health Tribunals should be empowered to allow a patient's transfer to a lower level of hospital security.
2. A legislative solution should be found to tackle the 'double jeopardy' of prisoner-patients who have an indeterminate or fixed sentence being required to have both a Mental Health Tribunal and Parole Board hearing before conditional discharge to the community.
3. Section 45A (the hybrid order) of the MHA should be abolished.
4. The system of MoJ approval of section 17 leave of absence from hospital should be improved.

Part III of the MHA covers circumstances where patients may be admitted to and detained in hospital on the order of a court, or transferred to hospital from prison. It is guided by the principles that a court cannot commit a person to hospital under the MHA if the alleged offence is not punishable by imprisonment, and that a person who needs medical treatment in hospital for a mental disorder is entitled to it. As the Review recognises, there are problems around 'the time required to take decisions and arrange transfers for patients subject to criminal proceedings'. While there are many factors beyond the MHA, such as resourcing, which impact on delays in such transfers, there are reforms to Part III of the MHA that should be considered.

### **Background and key issues**

- There are widespread concerns that offender-patients remain in conditions of higher security than they need, and for increasing

periods of time. There is evidence<sup>43 44</sup> that the introduction of medium security hospital units, while perhaps reducing the number of admissions to high secure hospitals, creates a preference for 'step-down' pathways of care with a net increase in the length of time patients spend in a secure hospital – without any commensurate fall in re-offending. There is also evidence from high secure hospitals that Mental Health Tribunals would be more likely to recommend transfer to lower levels of security than order discharge, but that their recommendations had little effect.<sup>45</sup> Legislation in Scotland works to the principle of a least restrictive alternative with a legal right to appeal against excessive security, supported by a two-step provision for appeals.<sup>46</sup>

- This change was legislated by the Mental Health (Care and Treatment) (Scotland) Act 2003. Combined with the establishment of four new medium secure units, it has led to a significant reduction in the numbers of people detained at the highest level of hospital security – from a consistent high of 230 before the 2003 Act, to 120 per annum or less in 2014–2016, and 111 in 2017.<sup>47 48</sup> The combination of enhanced service provision and a mechanism for significantly reducing delays in transfer has resulted in markedly improved patients care. In England and Wales, it is common for transfer arrangements to be agreed in principle between clinicians, but the transfer to be delayed because the Mental Health Tribunal may only recommend transfer rather than order it.

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<sup>43</sup> Jamieson L, Taylor P, (2005) 'Patients leaving an English high security hospital. Do discharge cohorts and their progress change over time?' *International Journal of Forensic Mental Health* 4: 59-75

<sup>44</sup> Fazel S. et al. 'Patient outcomes following discharge from secure psychiatric hospitals: systematic review and meta-analysis' *The British Journal of Psychiatry* Jan 2016, 208 (1) 17-25;

<sup>45</sup> PJ Taylor, E Goldberg, M Leese, M Butwell and A Reed (1999) Limits to the value of Mental Health Review Tribunals for offender patients. *British Journal of Psychiatry* 174: 164 - 169.

<sup>46</sup> Mental Health (Care and Treatment) (Scotland) Act 2003, *Chapter 3, Part 17, sections 264 - 273*

<sup>47</sup> Information Services Division (2017), Hospital inpatient care of people with mental health problems in Scotland: Trends up to 31 March 2016, 14 March 2017. Available at: <http://www.isdscotland.org/Health-Topics/Mental-Health/Publications/data-tables2017.asp?id=1853#1853>

<sup>48</sup> Scottish Government (2017) Inpatient Census - Part 1: Mental Health & Learning Disability Inpatient Bed Census 2017 <http://www.gov.scot/Publications/2017/09/9675/downloads#res524674>

- Anyone serving a prison sentence may be transferred to hospital for treatment of a mental disorder if two doctors recommend it. Transfers are common and they are more difficult to manage safely when the sentence is indeterminate or fixed. People subject to such sentences require a Parole Board hearing in addition to a Mental Health Tribunal hearing to be discharged from hospital once they have served their minimum period in custody (tariff). Following successful treatment in hospital, it is not unusual for a Tribunal to be content to order discharge. However, discharge is often considerably delayed (by up to 18 months) while waiting for a Parole Board hearing to be convened. In most cases, the Parole Board does ultimately endorse release on licence. This delay significantly affects length of stay for patients, which in turn has consequences for patient recovery pathways, availability of beds for more acutely unwell patients and their timely admission, and the cost of managing each individual case. Returning such a patient to prison would generally set back the treatment progress and disrupt relationships with the clinical team. It would also be likely to jeopardise public safety.
- Section 45A of the MHA allows for a sentence of imprisonment to be coupled with an immediate direction to hospital, rather than a hospital order because a person's mental disorder is considered sufficiently severe to require hospital care. However, the offender-patient would be redirected to prison when sufficient recovery has judged to have been achieved. Although absolute numbers of such orders remain small, they have been rising (seven in 2015/16, nine in 2014/15, up from two in 2013/14 and three in 2012/13<sup>49</sup>). Current sentencing guidance appears to put judges under pressure to implement it. This is unnecessary, expensive to administer, and potentially unsafe for both the offender-patient and the wider public.

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<sup>49</sup> NHS Digital, Mental Health Act Statistics, Annual Figures: 2016-17, Experimental statistics. Available at: <https://digital.nhs.uk/catalogue/PUB30105>

- It is essential for public and patient safety that patient progress can be tested out in a timely way before decisions about discharge or transfer to lower security are attempted. Many small decisions on the therapeutic and rehabilitative pathway of patients subject to a restriction order (under section 41 of the MHA) require approval from the Mental Health Unit within the MoJ. Concern among forensic psychiatrists has grown about the role of the Unit since it effectively ceased work for six months during an office move, and is now insufficiently staffed to provide a safe and adequate service. It is currently usual for simple requests (e.g. to attend outside non-emergency hospital appointments) to take over six months to be processed. True rehabilitative decisions take much longer. Decisions regarding leave for restricted patients are entirely the gift of a government minister, without any appeal process (other than judicial review). A hospital order patient under restrictions on discharge (section 41) has, by definition, been considered by the court to pose a risk to the public. Clinicians, in particular RCs under the MHA, fully appreciate the value of shared decision-making on steps in the rehabilitative pathway which involve any access to the community outside the secure perimeter of the hospital unit.

### **Proposals – Reforms to Part III**

- **Patient transfer to a lower level of hospital security** – the range of options open to a Mental Health Tribunal should be extended so that where appropriate, in addition to their current ability to order a conditional discharge, they could also transfer patients to a lower level of security. This would ensure proportionality in the system of detention, enhance patient trust and experience of care as well as promoting more efficient use of resources.
- **Removing the ‘double jeopardy’** – there should be legislative change to allow for prisoners who become detained hospital inpatients and

have an indeterminate or fixed sentence to have a single hearing on questions of release, rather than having to be assessed by a Mental Health Tribunal and Parole Board. This could include joint and/or delegated hearings being enshrined in mental health legislation, which is helped by the similar operating models for Tribunal and Parole Board hearings. It would need to be supported by stakeholders – including sentencers, the Parole Board, and Administrative Justice and Tribunals Council – and would be aligned with the spirit of the 2016 joint statement from the Ministry of Justice and HM Courts and Tribunals Service.<sup>50</sup>

- **Abolishing section 45A (the hybrid order)** – section 45A of the MHA should be removed as it is problematic. Current sentencing guidance appears to put judges under pressure to implement it ‘in cases where medical evidence suggests mental disorder, the offending is partly or wholly attributable to that disorder, treatment is available and a hospital order may be appropriate, the court should consider (and, if appropriate make) a s.45A order before considering a hospital order’. There are also false premises inherent in the safety aspects of section 45A. For example, in relation to its role enhancing public safety, this is based on the assumption that a Tribunal is weaker than the Parole Board despite a lack of evidence that the former’s decisions are riskier and/or more lenient, or that they have resulted in more harm. In relation to patient safety, it assumes that, once treated, a person who has a serious mental disorder is safe to be punished in the ordinary way. This is challenged by the very high rates of mental health disorders among prisoners, particularly suicide and self-harm rates.
- **Approval of section 17 leave of absence from hospital** – the inefficient system of MoJ approval of supervised testing outside the secure hospital perimeter should be improved. This could be achieved

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<sup>50</sup> Ministry of Justice (2016) *Transforming our justice system – joint statement*. Available at: <https://www.gov.uk/government/publications/transforming-our-justice-system-joint-statement>

through the preparation of a risk assessment and management report on each detained patient between six and 12 months after admission which would set out proposals for the management of leave decisions. This would need to be reviewed and endorsed, in whole or in part, by an external body. Some decisions in some cases would thereafter be devolved to the RC; others might rest with an external body, with reasons for the decisions documented. This leave and risk management plan would be reviewed periodically at Mental Health Tribunal Hearings by the Tribunal. Where decision-making powers are not devolved to the RC for specified types of leave, timescales for decisions should be set in the Code of Practice. The external body could be a revitalised MoJ Mental Health Unit, the Department of Health or another authority. We do not feel this should be a further role for the Mental Health Tribunal as patients ought to have a right of appeal on any substantial decision which would affect their longer-term progress.

## Child and Adolescent Psychiatry

### **Recommendation: There should be clarification of the:**

- scope of parental responsibility
- interface between Police Protection Orders (PPOs) and section 136 of the MHA in relation to children and young people
- interface between section 25 of the Children Act 1989 and sections 2 and 3 MHA 1983.

As the MHA covers children and adolescents, as well as adults, it is important for the Review to give special consideration to this group. There are number of ambiguities in how the MHA applies to this group and interacts with other legislation, that create challenges for the patient and the clinician.

### **Background and key issues**

- The MHA may be applied to people of all ages, including children and young people. This creates difficulty in deciding on capability both in relation to deprivation of liberty and consent to treatment, particularly in relation to the scope of parental responsibility. Case law on this aspect has either favoured parents being able to consent to treatment (including cases amounting to a deprivation of liberty) while being subject to a Supreme Court appeal, or has emphasised young people's autonomy. This uncertainty makes clinical judgements difficult, often in emergency situations, and could result in clinicians taking the most cautious, and so the most restrictive, option of detention.
- Section 136 of the MHA overlaps with the powers contained in the Children Act 1989 (section 46 - PPOs). For example, detention under the MHA is primarily because a young person is mentally ill and needs hospital treatment, while detention under the Children Act is

appropriate when care and control is because of disturbed behaviour. However, it is not always obvious whether children who are behaviourally disturbed are suffering from a mental disorder. This may be even harder for a police officer to determine. In such cases, use of section 46 may be a less restrictive option and in the better interest of the child. If a child, subject to a PPO, is subsequently suspected to have a mental disorder, a mental health assessment can be arranged under section 136, if required. This is generally seen as more stigmatising and more likely to 'commit' a child or young person to a longer-term restrictive mental health pathway (via section 2 or section 3 MHA 1983) than a PPO. With the recent reduction in duration of section 136 from 72 to 24 hours, there are concerns that more children detained under section 136 are going to be made liable to longer detentions under sections 2 or 3 due to insufficient time to arrange alternative options that are less restrictive. Conversely, as the duration of a PPO is still 72 hours, there may be a reduced risk of a child subject to PPO being detained under section 2 or section 3 (as there is more time for the crisis to be resolved and for alternatives to hospital admission to be sought).

- The MHA and the Children Act 1989 have provisions for longer periods of deprivation of liberty where a young person's care or mental health needs require this for safety. Their use depends on whether the deprivation is for care or for mental health treatment. However, this lacks clarity when a child's behavioural disturbance does not clearly arise from their mental disorder, though it poses a risk of harm to themselves and or others. This can result in vulnerable young people being inappropriately left in A&E or on paediatric wards while health and social care professionals consider how to apply the law.

## Proposals – Child and Adolescent Psychiatry

- **Scope of parental responsibility** – greater clarity is needed on the scope of parental responsibility, which should take account of ongoing legal cases. This includes clarity on:
  1. whether and when a person with parental responsibility can consent to the confinement of their child
  2. whether and when a person with parental responsibility can consent to medical treatment for mental disorder of their child
  3. whether (1.) or (2.) should differ depending upon whether child is below or above 16
  4. the statutory protections for a child who has been informally admitted and/or is being informally treated on the basis of parental consent.
- **Interface between PPOs and section 136** – There is a need for:
  - clear guidance on the use of PPOs and section 136 in relation to children and young people, and how its implementation should be monitored and reviewed
  - a mechanism for monitoring the effect of the reduction of the duration of section 136 from 72 hours to 24 hours, as there are concerns that this could increase detention rates among children and young people by allowing less time to source alternatives to hospital admission.
- **Interface between section 25 of the Children Act and sections 2 and 3 of the MHA** – the Codes of Practice for the MHA and the Children Act 1989 should be updated. This should set out a clear multi-agency process to determine, without delay, when each piece of legislation would be more appropriate to authorise longer periods of deprivation of liberty where a young person’s care or mental health needs require this for safety.

## Intellectual Disability

**Recommendation: 'Learning disability' should remain within the remit of the MHA, referred to as 'intellectual disability', with the criteria for 'abnormally aggressive or seriously irresponsible /conduct' reviewed. The DoLS process and Mental Capacity Act should be strengthened in relation to aggressive patients deemed unable to make treatment**

People with intellectual disabilities are an important group for consideration in relation to the MHA, and RCPsych wants to ensure it addresses their specific needs in a transparent and clear way.

### Background and key issues

- The term 'mental disorders' in the MHA includes not just mental illnesses, but a range of other conditions that include developmental disorders like 'learning disability'.
- If the disorder constitutes learning disability, the MHA includes an additional safeguard whereby patients can only be detained under the MHA with 'abnormally aggressive' or 'seriously irresponsible' conduct.

### Proposals - intellectual disability

- Learning disability should remain within the remit of the MHA, with the following changes.
  - It should be referred to as 'intellectual disability', as this is the more widely-used term internationally.
  - The term and practice related to the safeguard of 'abnormally aggressive or seriously irresponsible conduct' should be revised to have more objective criteria. Its current definition is subjective, and there are concerns that it is being wrongly interpreted to cover

challenging behaviour which may be due to physical illnesses, environmental changes or lack of services.<sup>51 52</sup>

- Additional qualifiers are needed when considering ‘abnormally aggressive or seriously irresponsible conduct’, including the care environment, physical health interface and communication issues. These need to be explicit within the Code of Practice and developed to ensure they are routinely considered within the assessment of mental disorders and people with intellectual disability, and tackled as part of a holistic package of care, if required.
- These safeguards should apply equally for compulsory detentions for assessment or treatment.
- For those presenting with aggression towards themselves or others, but who are deemed to be non-capacitous to make treatment decisions, we propose strengthening the DoLS process and the Mental Capacity Act.

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<sup>51</sup> The Masked AMHP (2016), ‘What is ‘Mental Disorder’ Within the Meaning of the Mental Health Act?’ Available at: <http://themaskeamhp.blogspot.co.uk/2016/01/>

<sup>52</sup> Brown, R. *The Approved Mental Health Professional's Guide to Mental Health Law*, Bournemouth University, 2016.