

# Reforming the Mental Health Act White Paper: Royal College of Psychiatrists Submission

21.04.2021

## About this submission

This is The Royal College of Psychiatrists' (RCPsych) submission to the Department of Health and Social Care's (DHSC) White Paper on The Mental Health Act. It is presented in the pro-forma consultation document provided by the DHSC. The views represented in this submission are based on consultation across the College, specifically through engagement with faculties and committees as well as a member survey, the results of which we attach with this submission.

The College has worked to reflect a wide variety of feeling on the MHA among our members and has done its best to reflect the nuance of debate in many areas. Hence in many cases the College has selected, as per the options supplied by the DHSC, 'not sure'. This is as so many of the proposed changes are contingent on many other areas of funding, workforce provision, practice, guidance etc. We look forward to continuing to work with the DHSC on the reforms and working to make sure the MHA works as well as it can for patients.

## Part 1

### 1. New guiding principles

There are 4 new guiding principles that people working to provide care will need to consider while carrying out their duties. These principles are central to our plans to modernise and improve the Mental Health Act. They are:

- choice and autonomy – making sure people's views and choices are respected
- least restriction – making sure the act's powers are used in the least restrictive way
- therapeutic benefit – making sure patients are supported to get better, so they can be discharged from the act as quickly as possible
- the person as an individual – making sure patients are viewed and treated as rounded individuals

Consultation question 1:

**We propose embedding the principles in the MHA and the MHA code of practice. Where else would you like to see the principles applied to ensure that they have an impact and are embedded in everyday practice?**

We welcome the Government's commitment to providing better, safer, fairer and more patient-centred services for people with a mental disorder requiring treatment. Notice of substantial new investment is particularly welcome and essential, particularly as a major driver towards minimising coercion in mental

health services is the provision of attractive and high-quality services for people in the early stages of illness or other disorder. Rejection of timely, appropriate treatment increases the risk of disorder deterioration to a point of necessarily coercive intervention. Almost all of the increase in application of detention under mental health legislation lies with the more acute civil provisions of the Act (especially section 2).

The broad principles expressed in the White Paper of *respecting patient choice and autonomy, least restrictive service provision, therapeutic benefit and individualised treatment* are welcome; they are principles to which psychiatrists already fully subscribe.

We therefore strongly object to the proposed qualification, effectively watering down the principles for Part 3 patients. The principles should apply to everyone liable to detention in hospital, or treated under community orders, under mental health legislation. This has been agreed public policy since the MHA 1959, then repeated in the 1983 Act. The White Paper assertion that the Wessely Review<sup>1</sup> supported different detention criteria for Part 3 patients is erroneous. Accordingly, we recommend a statement as follows, applicable to all detained patients:

*Mental health legislation is a tool for supporting the safe and effective treatment of individuals with a mental disorder and should only be applied when this cannot be achieved by agreement between the patient and clinicians, and the patient or others would be harmed in some way without recourse to the Act. Detention and treatment in hospital or coerced community treatment under the Act should not allow contradiction of, or in any way be inconsistent with, the core principles of treatment within medicine. This must apply to all patients and, consistent with the 1959 and 1983 Acts, no distinction should be made in this regard between Part 3 and Part 2 patients. In the view of the College, no such distinction is necessary or beneficial in securing public safety. The fact that patients detained under Part 3 of the Act may require higher degrees of restriction at some stages of their treatment than do most patients under Part 2, in no way affects the principles of optimising treatment choices, consent and using the least restrictive measures possible for the circumstances and how medical treatment proceeds. We also consider that such discrimination against Part 3 patients might leave the legislation open to legal challenge.*

We are, of course, supportive of the three planks of 'therapeutic benefit' within the meaning of the Act. The principle of 'therapeutic reciprocity', wherein infringement of civil liberty for the purpose of medical treatment should be 'matched' by the right to therapeutic resources sufficient for such treatment, should be explicit within the Act.

Confining the use of detention to situations where not using it would be likely to result in harms is, of course, reasonable. We should, however, be concerned about

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<sup>1</sup> Wessely S. Modernising the Mental Health Act: Increasing choice, reducing compulsion. UK government; 2018. Available at: <https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review> (Accessed on 19 April 2021)

the health, safety and welfare of all parties. It is unclear why a concept of 'safety' is applied only to others.

### **Digital Assessments**

Though digital mental health assessments are not specifically mentioned in the White Paper, there is reference to taking a 'first step in our work towards digitising the clinical pathways under the Act.'

We note that since then, there have been legal challenges to this and we would like to stress that the Government should work to ensure that virtual assessments are lawful and that this is guided more strictly in any accompanying code of practice. Without this, there is then the potential we will work at odds to many other areas of medicine as well as much of our current psychiatry provision. which is being effectively delivered virtually.

### **Embedding principles in the system**

Additionally, we would like to make some suggestions on how best to embed these new principles in the system:

- Embed these principles in Commissioning – Local Provider Collaboratives, Integrated Care Systems
- Make these principles part of the internal policy and operating procedures of all CQC registered organisations that may be involved in supporting people detained under the MHA.
- Embed these principles in the work of CQC and Mental Health Tribunal and link with MCA
- Make the guiding principles available/accessible for young people on the wards detained under the MHA in a format suitable for young people and for differing developmental levels of ability e.g. peer developed animation, information leaflets.
- Incorporate these principles in the section papers.

## **2. Clearer, stronger detention criteria**

Consultation question 2:

**We want to change the detention criteria so that detention must provide a therapeutic benefit to the individual. Do you agree or disagree with this proposal?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 2a:

**Please give reasons for your answer**

We agree that detention should be therapeutic, but it is important to have clarity over what exactly this means and how it is measured. For example, the idea of

what is therapeutic may differ between the individual and the clinician. Also, the provision of a safe place may be what is needed for someone's mental health – so the definition of “therapeutic benefit” would need to be broad enough to include both care and containment. Therefore, the meaning of ‘therapeutic benefit’ will be argued in great detail in tribunals ( assuming the amendments apply not only to the wording of sections 2 and 3, but also section 72 which sets out the criteria that tribunals must apply, which are very similar but not quite identical to those in sections 2 and 3).

Does it mean that the intention behind detention is to provide a therapeutic benefit, or does it mean that there must be actual therapeutic benefit that arises as a result of the detention?

The meaning of the term seems fairly clear for illnesses such as psychosis or depression, but is possibly much less clear for conditions such as dementia, Learning Disability (LD) or Autism Spectrum Disorder (ASD). Does it mean that detention must be likely to make the patient improve, or is it sufficient to demonstrate that it will help to reduce harm?

How will this apply to personality disorders where the benefit is perhaps more likely to accrue to others than to the patient? In the past there was a 'treatability' clause to Sec 3 which meant that, in some circumstances, people could not be detained unless their condition was 'treatable'.

Similarly, some other treatments may take a longer time to be of benefit e.g. in the case of brain injury rehabilitation – given more frequent tribunals the benefit may not be evident at a particular point in time.

It is also not possible to be certain in advance that detention will provide a therapeutic benefit, since a proportion of patients may not benefit from detention. So there needs to be a wording along the lines of 'detention is likely to provide a therapeutic benefit'.

It would also be very hard to understand why some very ill people were not admitted, on the basis that they wouldn't get any better.

Consultation question 3:

**We also want to change the detention criteria so that an individual is only detained if there is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person. Do you agree or disagree with this change?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 3a:

**Please give reasons for your answer**

We agree in principle but the use of the words “substantial” and “significant” are open to interpretation which will allow for discretion but also wide variation in interpretation and can have different meanings for lawyers and clinicians. We maintain that the decision about what constitutes a substantial likelihood and significant harm should be a clinical decision rather than a legal one.

We are also concerned that this is in contravention of many risk management and relapse prevention plans which look to intervene at the earliest opportunity before risk becomes “substantial and significant” in the non-consenting patient who lacks insight. Current tools to measure/predict risk, especially in young people are not very robust and not always used – perhaps the code could include more guidance about how this is measured?

Although we do not believe that detentions will be significantly changed as regards the decision to detain, given the vagueness and subjectivity of the wording, detentions will be more open to challenge.

### **3. Giving patients more rights to challenge detention**

Consultation question 4:

**Do you agree or disagree with the proposed timetable for automatic referrals to the Mental Health Tribunal (see [table 1](#) for details)?**

#### **1) Patients on a section 3**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

#### **2) Patients on a community treatment order (CTO)**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

#### **3) Patients subject to part 3**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

#### **4) Patients on a conditional discharge**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*

- not sure

Consultation question 4a:

**Please give reasons for your answer**

Though we agree that it may be beneficial for patients to have the opportunity to challenge their detention more frequently. We wonder if it would be better if the frequency with which they could **request** a tribunal should be increased, rather than being automatically referred for one. We also worry that such regular tribunals may challenge patients' sense of their secure base in hospital, as they may frequently become preoccupied with whether or not their placement will continue.

Increasing the frequency of tribunals will also increase workload and would need to be matched with resources – the workforce implications of this would need to be carefully considered with a costed feasible delivery plan. We would hope that before any changes are made, a very careful calculation of expected increase in workload would be made.

An increased number of tribunals would also require an increased number of specialists available to do these. Already, there is not always a child and adolescent psychiatrist on the panel for young people, or a Learning Disability (LD) psychiatrist on the panel for a young person with LD. These should be essential pre-requisites for a tribunal to take place when seeing a young person, or a person with LD. However, there is a significant shortage of these specialty psychiatrists already within the workforce, and particularly within inpatient settings (15% vacancy rates for CAPs). Increased workload for tribunals would mean that time would be removed from the daily duties which would impact on quality of care.

We are concerned that if not matched with appropriate resources and if guidelines for essential panel members are not set out, then the increase in tribunals could lead to a reduction in the number of people on the panels and this could ultimately reduce, rather than increase, patient safeguards.

Additionally, there are a great number of patient groups who could be let down by the automatic proposals as patients have often expressed concerns that there are already too many tribunals, often not optimally timed, with many patients finding them stressful. Similarly, many young people don't want to appeal against their detentions as they find the experience of the tribunal traumatic. This needs to be taken into consideration and they should be as child/young person friendly as possible. Ideally the young person should have peer created information about what a tribunal is and how it works before going in for one. Also enhanced training is urgently required for tribunal panels and judges regarding how the process could be adapted to be more Children and Young People (CYP) friendly, with formal recommendations for amended procedures which should be co-produced with CYP.

We note that in our survey of members, the majority of members were happy to see the proposed changes in timeframe. We approve providing more rights to patients but on a whole, our view is that focus should be on improvement of quality rather than quantity of tribunals. This would generally include more

involvement of carers. Patients should have the right to defer or even cancel a hearing providing they have access to legal advice.

**Proposal to extend 14-day time limit on patients detained under section 2 of the Act, making an application for discharge to the Tribunal to 21 days, to give patients (or their representative) greater opportunity to appeal their detention.**

We are wary that this narrows the window of time to organise the tribunal, presenting a considerable administrative challenge. Even under current rules, tribunals may take place within a few days of the end of the section which seems to add little to the protection of patient rights.

**Proposal to increase opportunities for patients detained under section 3 of the Act, to appeal to the Tribunal in the first 12 months of detention, to three (up from the current two).**

Same as above

**Proposal to create a new statutory power for Independent Mental Health Advocates (IMHAs) to apply to the Tribunal to challenge the patient's detention on their behalf. This will be in addition to the Nominated Person who can also apply to the Tribunal in certain circumstances, in line with the current powers of the Nearest Relative.**

This additional safeguard has the potential to create a substantial increase in administrative load for the tribunal and clinicians. Thought needs to be given to the situation of patients who lack capacity to decide to make an application but are not objecting. In these cases, an IMHA may feel that they need to make an application to the tribunal just to show that they are properly safeguarding patient rights, even though the patient may not wish to apply and there may not be clear reasons to make an application. We suggest that the IMHA should have the right to recommend to NR or hospital managers (or possibly also the Secretary of State), giving reasons, that an application be made, but not an unrestricted right to make an application on behalf of the patient.

[Changes to the tribunal's responsibilities](#)

Consultation question 5:

**We want to remove the automatic referral to a tribunal received by service users when their community treatment order is revoked. Do you agree or disagree with this proposal?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 5a:

**Please give reasons for your answer**

Agree only if the patient has a right to make an application for a Tribunal review within a short period of the revocation, say within 28 days of the revocation.

## **Giving the Tribunal more power to grant leave, transfers and community services**

Consultation question 6:

We want to give the Mental Health Tribunal more power to grant leave, transfers and **community services**.

**We propose that health and local authorities should be given 5 weeks to deliver on directions made by the Mental Health Tribunal. Do you agree or disagree that this is an appropriate amount of time?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 6a:

**Please give reasons for your answer**

Five weeks does seem like a reasonable timeframe to review recommendations, as long as this is matched with the provision of resources to enable delivery of the directives from the tribunals.

**Giving the Tribunal the power to determine if the current setting represents the least restrictive option or if other options are available that better support the recovery of the patient and their path to discharge.**

We have argued for this in the past and are disappointed to see that, insofar as powers might be increased, they would be denied to the highest level of tribunal, chaired by experienced lawyers with judicial experience. This seems to go against the principles set out in the White Paper and to show a disturbing lack of confidence in the judiciary and other highly trained tribunal members.

**Proposal to extend the role of the Tribunal, when considering applications for discharge, to give it the power to grant leave, transfer patients**

However, we do not think it is appropriate to increase the powers of tribunals to grant leave and make transfers. Leave should be a clinical decision planned by the Responsible Clinician (RC) and multidisciplinary team and ultimately decided by nursing staff assessment at the time of leaving the unit. It would be impractical and potentially unsafe for the tribunal to be making these decisions as they would not necessarily have all of the information necessary and risks can fluctuate on a day-by-day basis.

This appears to invite Tribunal to cross the line from reviewing detention into making directions about care and treatment, which at present it does not do. A tribunal meeting on one occasion is unlikely to have sufficient knowledge of local services and arrangements to be able to do this meaningfully.

We are concerned that there would be a lack of clarity about where the responsibility would lie if something is directed by the tribunal but goes against the recommendations of the Responsible Clinician (RC).



How will a tribunal panel know what community services could be available in that particular area? Panels currently decide on detention on the basis of the person meeting or not meeting clear legal criteria. There are no legal criteria about whether or not someone should be given leave or transferred, so what would a panel base its decision upon?

Additionally, this is extremely unlikely to be implemented or successful given current under resourcing for neuropsychiatric community services/rehabilitation. This will also rely on services having access to LA care coordinators which, given the shortage of social workers, again is very unrealistic. It also creates negativity in the relationship with the treating team and the patient/ local authority. Resources need to match legislative change and we are not nearly close to this being possible.

Tribunals already have significant powers to make recommendations and turning these into directions with legal weight could be counter-productive and potentially slow-up processes should the directions not be possible or appropriate for the reasons given above.

### [Hospital managers' hearings](#)

Consultation question 7:

**Do you agree or disagree with the proposal to remove the role of the managers' panel in reviewing a patient's case for discharge from detention or a community treatment order?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 7a:

**Please give reasons for your answer**

We believe it is safer for these serious decisions to be made by Tribunals where the legal and medical expertise is higher and more quality assured. Managers' hearings are a difficult concept to understand e.g. explaining what they are and their role to young people can be difficult. They add additional paperwork and appears at times pointless to both clinicians and patients – this has become even more evident during the pandemic. Given that MHRTs will increase in frequency, there will also be an increase in work load that removal of HMR will mitigate.

Although, we will need to make sure that removing this process does not remove another safeguard for people detained under the MHA.

Frequency of referrals for MHRT will inevitably increase work load in report writing and in searching for suitable alternatives to detention particularly when a specialist placement is required. Given the increased powers of MHRT proposed there absolutely needs to be LA care coordination representation at MHRTs.

Resources for community services are inadequate with wide geographical variations – these need to increase in order to offer a least restrictive environment for admission and discharge.

#### **4. Strengthening the patient's right to choose and refuse treatment**

Advance choice documents will follow a standard format and approach, and should include the following information about an individual's preferences (including on treatment and non-medical therapeutic approaches, as well as any other information deemed relevant by the individual):

- Any treatments the person does not wish to consent to as well as their preferred clinically appropriate treatments
- Preferences and refusals on how treatments are administered (for example refusal of suppositories, or preference for care staff of a particular gender to avoid retraumatising them, given the relationship between gender-based violence and trauma)
- Name of their chosen nominated person
- Names of anyone who should be informed of their detention, care and treatment (including specific instructions on which individual should get what information)
- Communication preferences
- Behaviours to be aware of which may indicate early signs of relapse
- Circumstances which may indicate that the person has lost the relevant capacity to make relevant decisions
- Religious or cultural requirements
- Crisis planning arrangements, including information about care of children/other dependents, pets, employment, housing etc
- Other health needs and/or reasonable adjustments that might be required for individuals with a disability or learning disability and for autistic people

Consultation question 8:

**Do you have any other suggestions for what should be included in a person's advance choice document?**

- The document should also include information about management of disturbed behaviour including restraint, seclusion and searches. For example, if they have previous experience of restraint, what position has been least distressing? What is a trigger? If they have had previous searches, are there any instructions that make these less distressing?
- It would be helpful if there was a way of indicating previous experience that has influenced the decision they are making.
- For young people, preferences about how they want to remain in contact with family and friends could be useful.
- For young people, the involvement of a parent/guardian in the creation of the document should be considered where appropriate – have they been informed of the contents and if not, have the reasons for this been discussed and documented?

- There are similarities with a Patient's Passport or 'This is Me' type of document, file or app, which is used to find out more about the person behind the illness. It could be adapted to cater for different ages, and go with the patient as they transition.
- There could be a parent/carer section with specific themes that support the main document.
- There should be provision for disabled patients who struggle to understand verbal communication or cannot vocalise their true emotions in a verbal format, for example, deaf patients or patients with LD. This should ensure sign language interpreters, Makaton interpreters or texting style devices are available for nonverbal communication.
- Inclusion of the patient's wishes if their physical health should deteriorate.
- It should include a review of the extent of permitted refusals of treatment for patients subject to detention. For example, if a patient with capacity makes an advance decision to refuse all future antipsychotic treatment, it needs to be clear that refusal can be overridden in the case of a detained patient.

Consultation question 9:

**Do you agree or disagree that the validity of an advance choice document should depend on whether the statements made in the document were made with capacity and apply to the treatment in question, as is the case under the Mental Capacity Act?**

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Consultation question 9a:

**Please give reasons for your answer**

The RC is already legally obliged to take into account the expressed wishes of the patient in reaching a best interest decision as set out in MCA section 4(6)(a).

It is a weakness of the advance refusals sections of MCA that there are so many reasons why an advance refusal can be overruled. These include lack of capacity at the time of making them, almost anything which the patient has said or done since then which might indicate a change of mind, and developments in the understanding or treatment of mental illness which might not have been foreseen at the time the advance refusal was made.

These problems are difficult to overcome if advance choice documents (ACDs) are binding on the RC. In our view, advance decisions should be given the status of an expression of wishes which must be considered but which could be overruled if the RC thinks it necessary. Perhaps there could be a new review process, for example, if an RC wishes to overrule an advance decision a second opinion must be obtained. This might not be in time for urgent treatment decisions, so there could be a similar set of rules as now for SOAD reviews.

The SOAD service is already under enormous pressure, and attention will have to be given to better supporting it if their role is to be extended.

### **Children and Young People**

We agree that capacity in making advance choices for under 18s and again in the under 16s, as well as consideration of the fact that the choices and preferences in the document vary greatly in terms of the potential long-term consequences for the individual.

Elements of the advance choice document carry more 'weight' than others and will require honest discussion at the time they are made. For example, if a 16 year old with capacity said they did not want to be admitted to hospital under the MHA even if life was in danger, it is hard to imagine that this would be upheld if they lost capacity. It also contradicts the Children Act, which contains obligations to act in the best interest of the child (anyone under 18). Some elements of the document may not carry the same consequences, for example communication preferences, and so the test for understanding this may not need to be as rigorous.

If ACDs are to apply to those under 16, which we believe they should, there needs to be clear definition of how 'competence' is assessed and who should be able to do this. Perhaps this should be incorporated into the Act itself to remove the current ambiguity about this.

It is also important that the young person/carer is aware of what is being decided, why and how – and also the implications, or potential longer-term implications of that decision, with access to advocacy and full information to make that informed decision.

Further clarity will be required in the following areas:

- The issues of capacity and competence have not been clearly defined or outlined, which could make a person who has a disability and has capacity to make those decisions more vulnerable to losing their ability to communicate their wishes.
- Which professionals should be involved, for example should this be a senior clinician, and should they be witnessed?
- The consideration of significant implications for the wellbeing of the patient, for example, if the patient is completing ACD and is manic or depressed.
- Would the ACD be completed for differing presentations? For example, if the patient presents with organic delusional disorder but later develops dementia, what would a review process look like?
- What happens with respect to the nominated person if circumstances should change, for example in the case of divorce?

### [Making care and treatment plans statutory](#)

We believe that a care and treatment plan should include the following information:

- The full range of treatment and support available to the patient (which may be provided by a range of health and care organisations)
- For patients who have the relevant capacity and are able to consent, any care which could be delivered without compulsory treatment
- Why the compulsory elements of treatment are needed
- What is the least restrictive way in which the care could be delivered
- Any areas of unmet need (medical and social) for example where the patient's preferred treatment is unavailable at the hospital
- Planning for discharge and estimated discharge dates (with a link to s117 aftercare)
- How advance choice documents and the current and past wishes of the patient (and family and/or carers, where appropriate) have informed the plan, including any reasons why these should not be followed
- For people with a Learning Disability, how Care (Education) and Treatment Reviews, where available, have informed the plan, including any reasons why these should not be followed
- An acknowledgement of any protected characteristics, for example any known cultural needs, and how the plan will take account of these
- A plan for readmittance after discharge, for example informal admission, use of civil sections, or recall by the Justice Secretary

#### Consultation question 10:

#### **Do you have any other suggestions for what should be included in a person's care and treatment plans?**

We think that outlining care and treatment plans in the medical record is vital but do not consider that a *detailed plan* should be a statutory requirement. For many people whose disorder is serious enough to warrant their detention, that disorder may fluctuate considerably and rapidly. Confining clinicians to a detailed statutory plan may well, on occasions, risk serious harm to the patient, or others, by impeding clinical judgement and action.

Whilst the potential dangers to the patient, or others, arising from this proposal would constitute the most serious unintended consequence, the cost of maintaining detailed plans in a form that would constitute legal documents would be very high. Without a substantial injection of resource, it would make far less time available for working with the patient. Furthermore, formally making the patient's care and treatment plan subject to scrutiny from the clinical or medical director would effectively undermine the independence and authority of the patient's RC and would result in the clinical or medical director being ultimately in charge of and responsible for the patient's treatment. This is neither workable nor beneficial for the patient.

Further suggestions for what should be included in a person's care and treatment plans are as follows:

- Issues of seclusion/restraint/search
- Potentially difficult anniversaries of events

- Issues around the sharing of information, which is especially important for young people
- For under 25s – should this be linked to EHCP?

[A new framework for patient consent and refusal of medical treatment](#)

Consultation question 11:

**Do you agree or disagree that patients with capacity who are refusing treatment should have the right to have their wishes respected even if the treatment is considered immediately necessary to alleviate serious suffering?**

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Consultation question 11a:

**Please give reasons for your answer**

Overriding a capacitous treatment refusal is a very serious matter. It is a major intrusion into a person's life, to their liberty, their right to self-determination and to the preservation of their bodily and psychological integrity. Under current practice however, where this is judged necessary for reasons of safety or substantial benefit, and refusal is at least in part arising from the patient's mental state, there is a mechanism for overriding refusal of such beneficial interventions.

Overriding a refusal of treatment in an emergency in which a life is immediately at stake or there is a clear and immediate risk of serious, irreversible harm can be readily justified on the grounds that it may not be clear in the moment whether the person does in fact have capacity.

However, in the absence of an emergency, where the refusal is being clearly made by a person with capacity, there are potential violations of human rights incurred by overriding a refusal. The baseline is set by the place of capacity in non-psychiatric inpatients. Treatment refusals are accepted no matter the gravity of the outcome.

### **Defining capacity**

One of the frequent problems in discussing the application of 'capacity' and 'best interests' in practice is the lack of clarity of what those terms mean. Their meaning is evolving with a significant move away from a purely 'cognitive' or 'procedural' assessment to one that incorporates an examination of a treatment decision in the context of the person's relatively stable, deeply held beliefs and values, commitments and their personal life goals.

Assessment of capacity in many circumstances can be unreliable and difficult. We are aware of a large disparity between the idea of capacity as often discussed and the way it is applied in everyday frontline practice. However, there is evidence that capacity can be assessed with a great degree of reliability and we would

welcome a concerted effort to prioritise methods that allow this and ways in which this can be measured.

The success of this proposal in improving the rights of and care for patients will depend greatly on the way in which capacity is understood, and in turn how this understanding translates into practice. Frontline clinicians working with high-risk cohorts, will often be treating patients who are well *because* they are treated but who have minimal or no awareness of their illness. Decisions on whether these patients are capacitous are likely to be very difficult to make.

The Wessely report produced five “confidence tests” in the roadmap towards unifying capacity-based legislation which would result in admission and treatment never being lawful in the face of a capacitous refusal.<sup>2</sup> The third of these is “whether the assessment of capacity is reliable enough to provide the sole basis for care and treatment”.

There are conflicting views among psychiatrists as to whether this is currently the case and on how close we are to arriving at this point. We stress that achieving this is very important to keep patients safe when making any of the changes proposed, but also note that the current test in the MHA diagnosis and risk would also likely fail the same test.

### **Capacity and access to services**

Outside of academic discussions of the definition of capacity, we have heard anecdotally of some instances where “capacity” is being used not to protect people’s rights but rather as a justification for denying access to services and withholding treatment from patients expressing suicidal ideas. Such a provision could thus have a disproportionate effect on groups with whom there is already concern about access, for example, minority communities with different cultural understanding of mental health difficulties or individuals with limited knowledge of English. This could lead to an inadequate capacity assessment, which is subsequently used to deny treatment otherwise deemed to be urgently necessary. A similar line could be taken by those seeking to prevent those with significant violence risk accessing services if this seems defensible. Avoiding this will require a significant focus on a reliable assessment of capacity.

### **Eating Disorders**

Capacity can be particularly hard to assess in Eating Disorder patients and those with anorexia nervosa can be very articulate yet lack capacity. The assessments can be clumsy and don’t pick up the incapacity, mainly because people are expecting patients to fail capacity tests due to things like inability to comprehend or retain information. However, people with anorexia nervosa, if they lack capacity, almost always fail on the ‘use and weigh’ criterion, which is where the eating disorder affects the values and judgements.

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<sup>2</sup> [Modernising the Mental Health Act: Final Report of the Independent Review of the Mental Health Act 1983 \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/672222/modernising-the-mental-health-act-final-report-of-the-independent-review-of-the-mental-health-act-1983.pdf)

The cases of patients that have gone to law courts were all deemed to lack capacity, even though they were all very eloquent in terms of expressing their wishes.<sup>3</sup>

### **Other patient groups**

These are complex decisions and may require support from trust legal teams or court directive and potentially further training as capacity assessment is still widely misunderstood and/or neglected. Often these decisions need to occur urgently in emergency departments and clinicians need access to urgent guidance in these situations and are unlikely to take the risk of not acting in the case of uncertainty. In a non-acute situation this decision should be made by a court.

We are concerned about the potential implications for those aged 16-17, and again for those aged under 16, who legally cannot refuse and again contradicts the Children's Act. There is also the question of parental rights.

### **Fluctuating capacity**

An added complication is fluctuation of capacity (especially in the context of coexisting substance use) and our current Code of Practice<sup>4</sup> specifically directs clinicians away from using capacity legislation as follows:

- *In considering whether or not the DoLS could be used, other reasons why it may be necessary to detain a patient under the Act and not rely on the MCA alone include the following:*
- *The patient's lack of capacity to consent or refuse is fluctuating or temporary and the patient is not expected to consent to admission or treatment when they regain capacity. This may be particularly relevant to patients having acute psychotic, manic or depressive episodes.*
- *The applicability of capacity measures in scenarios where the risk is to others*
- *A degree of restraint may need to be used which is justified by the risk to other people but which is not permissible under the MCA because, exceptionally, it cannot be said to be proportionate to the risk to the patient personally.*

### **Conclusion**

As discussed, the College is troubled by the current system in which capacitous patients can have their refusal overridden, potentially contravening their human rights, and in principle welcome a move towards the baseline set by the place of capacity in non-psychiatric inpatients.

However, as discussed, the exact nature of these proposals are as yet undefined and there remain some difficulties in practice in ascertaining capacity. Frequently, professionals disagree on whether a particular patient has capacity in

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<sup>3</sup> Tan JO, Passerini GE, Stewart A. Consent and confidentiality in clinical work with young people. *Clin Child Psychol Psychiatry*. 2007 Apr;12(2):191-210. doi: 10.1177/1359104507075921. PMID: 17533935.

<sup>4</sup> Department of Health. Code of Practice Mental Health Act 1983. London: TSO. 2015



relation to a specific matter. For these proposals to be implemented successfully, we would require the Government to follow the third test in the Wessely Review on whether the assessment of capacity is reliable enough to provide the main basis for care and treatment as follows:

*1. A better understanding of how capacity is currently used within the MHA. If our recommendations are implemented, we will get a much better picture of this in practice for both admission and treatment;*

*2. Action to prevent misuse of mental capacity. We (The Review) not agree with the Committee on the Rights of Persons with Disabilities that mental capacity is simply an invalid concept in the context of delivering care and treatment – in part because we cannot see any acceptable alternative. But we do agree an assessment of someone’s capacity can be misused. (...) Implementation of our other recommendations which introduce capacity elements into the MHA, (for instance in relation to ACDs) will already require measures to be taken to secure against this risk, but it will be important to evaluate the impact of these measures before moving any further;*

*3. Embedding decision-making assessments in the cultures of the professionals involved, supported by infrastructure and training. There also needs to be an agreed way to resolve disputes when professionals don’t agree on capacity. Again, we would expect this will develop if our recommendations are implemented; and*

*4. Research into how the legal test of decision-making capacity in the MCA can be translated into practice. This should include:*

- the concept of “using and weighing;”*
- the practical implications of the legal requirement for an “impairment or disturbance in the functioning of their mind or brain” to be the direct cause for someone’s inability to make a decision. This research should be multi-disciplinary, shaped by service users, and firmly linked to both practice and policy-makers.*

Consultation question 12:

**Do you agree or disagree that in addition to the power to require the responsible clinician to reconsider treatment decisions, the Mental Health Tribunal judge (sitting alone) should also be able to order that a specific treatment is not given?**

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Consultation question 12a:

**Please give reasons for your answer**

A tribunal judge is unlikely to have the clinical expertise to be able to weigh up the merits of one form of treatment over another, or to decide that no treatment at all

should be given. In general, courts are able to make a declaration that a particular course of treatment would be lawful, but it is more difficult to see that a legal member should be entitled to make clinical decisions directing that a particular treatment should or should not be given. Where courts make declarations that a particular course of treatment (or withdrawal of treatment) is lawful, that is only done after the most careful consideration with a considerable amount of expert evidence and legal argument, except in emergency situations (in which case a full hearing will normally follow very quickly).

This should ideally be a clinical decision made as a whole MDT, which is as collaborative as possible, but if the decision is highly contentious, it should be a matter for a higher court, for example the court of protection.

Our survey of RC Psych members was very clear on this with 83% disagreeing or strongly disagreeing with this proposal.

## **5. Improving support for people who are detained**

### Nominated person

The new nominated person will have the same rights and powers to act in the best interests of the patient as nearest relatives have now. These include rights to:

- object to the patient being made subject to the act
- apply for the patient's discharge
- appeal to the tribunal if this application for discharge is denied
- apply for the patient to be detained under the act
- receive information from the hospital about the patient's care, detention or community treatment order (CTO), unless the patient objects to this

In addition to the powers currently held by the nearest relative, we propose that the nominated person should also:

- have the right to be consulted on statutory care and treatment plans, to ensure they can provide information on the patient's wishes and preferences
- be consulted, rather than just notified, as is the case now, when it comes to transfers between hospitals, and renewals and extensions to the patient's detention or CTO
- be able to appeal clinical treatment decisions at the tribunal, if the patient lacks the relevant capacity to do so themselves and the appeal criteria are met
- have the power to object to the use of a CTO if it is in the best interests of the patient

To support nominated persons to access and exercise these enhanced powers we will provide clear, detailed guidance on the powers of the nominated person role.

Consultation question 13:

**Do you agree or disagree with the proposed additional powers of the nominated person?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 13a:

**Please give reasons for your answer**

We welcome the proposal for more flexibility here. It is particularly important for patients who come into forensic mental health services as it is not uncommon for a patient to have been abused by the legally designated nearest relative.

However, while welcoming the principle of this proposal, guidance on its implementation needs to take account of potential unintended consequences that some of our members have identified through discussions with our patient and carer representatives as well as members.

For example, there needs to be a mechanism for the Nominated Person (NP) to be displaced if they are not acting in the person's best interest or abusing the person. Also, appropriate safeguards will be required in the practice of some of the NP's powers, including their ability to object to the use of a CTO. If this objection has a veto like status, this would have the effect that a patient would be able to ask the NP to block a CTO on their behalf. As in many cases a NP is likely to be a friend or relative of the patient, they might feel torn between loyalty to the patient and their own view of what would be in the patient's best interests, with the risk of the wrong decision being made.

We have also received some concerns from members working in Eating Disorders Services, who have said due to the nature of eating disorders and lack of capacity, this will mean that the patient (of any age) would often try to undermine their loved ones who are trying to collaborate appropriately with clinicians to treat them. It is common for over-16 patients to refuse to allow their parents or carers to have any information or even talk to the treating team, and this situation will be made worse if they can displace these people altogether.

These concerns raise the need for safeguards around the nominated person issue, such as allowing the RC the right to be informed and to object.

Consultation question 14:

**Do you agree or disagree that someone under the age of 16 should be able to choose a nominated person (including someone who does not have parental responsibility for them), where they have the ability to understand the decision (known as 'Gillick competence')?**

- *strongly agree*
- *agree*

- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 14a:

**Please give reasons for your answer**

We agree that this is something that should be available to those under 16 but will need a lot of thought, even for those aged 16-17 for whom parents still have legal responsibility under the Children Act 1989.

For those under 18, it might be possible for the young person to have a nominated person who carries out roles for the purposes of the MHA, while someone else has parental responsibility who continues to exercise those rights under the Children Act 1989. This will cause potential conflicts and there needs to be a structure for under 18s to establish when and why it would be appropriate for a nominated person not to be a person with parental authority. The default position should remain that the nominated person is a parent or guardian unless there is a good reason otherwise.

As with ACD, the assessment of competence to make these decisions will need to be very clear, so clinicians can explain the choice to a potentially disagreeing parent.

We would recommend that a social worker/advocate is able to support the young person with their decision to avoid risks, in particular helping them to consider their own longer-term best interests as opposed to only their immediate desires.

There is also the need to consider what happens if someone doesn't want to (or can't) nominate someone; right to 'appeal' – for example, what happens if someone who does have parental responsibility disagrees with the choice – how is the decision made?

On the potential negative side, it could lead people to be more vulnerable to exploitation by older adults, for example, a 19 year old boyfriend becomes the nominated person and could apply for them to be detained under the mental health act even if they were of sound mind.

On the positive side, if the young person has poorer relations with parents, it enables flexibility for them to choose who they trust to handle their care.

Advocacy

Independent mental health advocates (IMHAs) are trained specifically to work within the framework of the act and to enable patients to participate in decision-making. They are currently responsible for supporting patients to understand:

- their legal rights under the act and those of the people who are able to act on their behalf
- the particular parts of the act which apply to them
- any conditions or restrictions to which they are subject

- any proposed or received medical treatment, and the reasons for that treatment
- the legal authority for providing that treatment
- the safeguards and other requirements of the act which would apply to that treatment

To ensure patients are able to benefit from the reforms to the act proposed in earlier chapters, we propose to expand the role of IMHAs to include the following additional safeguards:

- supporting patients to take part in care planning
- supporting individuals in preparing ACDs
- power to challenge a particular treatment where they have reason to believe that it is not in the patient's best interests
- power to appeal to the tribunal on the patient's behalf

#### Consultation question 15:

Do you agree with the proposed additional powers of independent mental health advocates?

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

#### Consultation question 15a:

##### **Please give reasons for your answer**

This is an extremely important service that should be available to all patients on request. It should not, however, be a substitute for legally qualified advice. Patients and carers that we have consulted with have said that, for this role, they particularly value the fact that an advocate is 'not in authority'. We are also aware that many carers would also welcome access to advocacy.

Whether or not the proposed changes will have a positive effect will depend on what is specifically meant by "power to challenge" and "power to appeal" – this is particularly relevant for patients who lack capacity due to cognitive impairment and also potentially sets an adversarial tone through its title. Perhaps

- "right to ask for review of treatment / best interests review" or
- "power to support patient to appeal"

may be more helpful and in keeping with a collaborative approach.

The advocate role should be strictly confined to supporting patients (and carers where possible). Insofar as the patient would like assistance from an advocate, that assistance should be limited to an enabling role. The task is to help the patient, where needed, to express their own concerns and wishes and to engage

more fully in their own care and treatment, working towards full, healthy independence. It is vital that the advocate makes no assumptions about the patient's wishes and does not seek to promote any agenda of their own. A good advocate would be working towards an early lack of need for their input because the patient would then have all the strengths needed to negotiate his/her own optimal care.

There are likely to be significant resource and training implications which would need to be met if these changes were made. It is important that the process does not introduce an administrative burden which is extremely difficult to meet and therefore risks introducing delays in the treatment process. The power of the NP to challenge a particular treatment needs to be spelled out as to exactly what 'challenge' means. Is it to block the treatment, or simply to raise a question about it?

Additionally, we need to consider specialist training for IMHAs working with young people. There is a specialist IMHA qualification, but this is not routinely asked for before work with young people is possible.

To date there is also limited scrutiny by the CQC etc. about how patients are informed about the availability of IMHAs and what IMHAs actually do. Monitoring of how IMHAs are being used, for example who is using them, or how long a time period is spent working with them, is also something that is crucial to the positive role that these individuals are supposed to play.

If an IMHA challenges treatment decisions, who then has responsibility? If this is a way of leading to further discussion about treatment then this is likely to be a positive thing, whereas if it automatically meant that the treatment did not happen, that would not be appropriate.

There also remains the possibility of IMHAs for those admitted voluntarily as well as involuntarily – especially in those under 16 who may be admitted under parental consent, which is a de facto involuntary admission.

Consultation question 16:

**Do you agree or disagree that advocacy services could be improved by:**

**1) enhanced standards**

- *strongly agree*
- **agree**
- *disagree*
- *strongly disagree*
- *not sure*

**2) regulation**

- *strongly agree*
- **agree**
- *disagree*
- *strongly disagree*
- *not sure*

### 3) enhanced accreditation

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

### 4) none of the above, but by other means

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 16a:

#### **Please give reasons for your answer**

There is a wide range of variability in the knowledge, expertise, and understanding of their role by IMHAs. Areas that demonstrate some of the issues are:

- In some cases, they do not stay in post for the duration of the person's detention so the patient has to repeatedly build up their relationship with new IMHAs, with the negative impact that can have for the patient.
- Some IMHAs find it difficult to limit their role to their statutory responsibilities and seek to make their own recommendations as to what would be in the patient's best interests, or provide their own assessments of capacity, rather than acting as a mouthpiece for the patient.

However, in defining the regulations it is important to acknowledge that advocates often have very different backgrounds. For example, they can come from the voluntary sector as well as from a healthcare professional background. If the regulations are too stringent this may result in a loss of some of the quality and benefits for the patients that come with this variety of backgrounds.

The White Paper also talks about the importance of culturally sensitive advocacy. Increased regulation will make it less likely to encourage a broad range of individuals in terms of background and experience into Advocacy.

There is potential for advocacy services to be improved with greater monitoring by the CQC and more questions being asked about the accreditation that IMHAs already have, rather than introducing new forms of accreditation. New forms of accreditation may become another 'tick box exercise' approach that does not lead to any improvement for patients.

Colleagues in neuropsychiatry have emphasised the need for training in the specialist area in which they work: – e.g.:

- brain injury awareness training;

- dementia;
- ASD training.

They have also asked for clarity on what accountability will IMHAs have in particular when supporting cognitively impaired patients. Will they have contracts with patients? How will their role differ from that of a MHL solicitor?

## 6. Community Treatment Orders (CTOs)

Though the White Paper does not specifically consult on CTOS, we would like to use this opportunity to provide our thoughts.

**The Government proposes to revise the criteria for using CTOs, in line with the proposed revised detention criteria for section 3, to ensure that CTOs are used in a more consistent way. The criteria will be changed so that a CTO can only be used when there is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person, and where a CTO will provide a therapeutic benefit to the patient.**

We do not think it is completely clear as to what constitutes “significant harm to the health, safety or welfare of the person, or the safety of any other person”. Is there any indication that imminence is a consideration? The population who are subject to CTOs are generally not the same as those who are in the process of detention under section 2 or 3. This comes very much down to whether *nature or degree* are being used to justify the use of the Act. Obviously, it is a question of *either rather than both* being required.

With CTOs it is often *nature* rather than *degree* that predominantly applies. The issue of therapeutic benefit falls into the same category, for example the prevention of deterioration being the intention, as opposed to treating someone who is acutely unwell.

Introducing 'substantial likelihood of...' criteria will not eliminate ethnic inequalities in the use of CTOs, as this does not address their root cause nor unconscious bias in risk assessments. In fact, it may make matters worse, by increasing the stigma associated with CTOs.

This would be unacceptable given that eliminating these ethnic inequalities is a key driver for the legislation.

### **Making, renewing and extending CTOs**

**The Government intends to introduce a third decision maker for CTOs. The initial decision to make a CTO will continue to be the responsibility of the Responsible Clinician and an AMHP. The Government will introduce a**



**requirement for the community supervising clinician who will work with the patient while on a CTO to also be involved in the decision.**

This requirement for agreement is welcomed but the supervising community clinician should not be expected to undertake a face to face assessment. This would be an unnecessary clinical burden and this was acknowledged in the Wessely Review to be the basis for this legislation. Best practice indicates that the community RC is consulted but they must not be required to see the patient in person at the start of the order.

Thought should also be given to a simple process which requires evidence of agreement from the three parties but no unnecessary three-step “countersigning”. It is hard to see what value such an approach has and so the need to countersign should be removed from commencement, renewals and revocations of CTOs.

**The Government will set an expectation that CTOs should end after a period of two years. The patient should be discharged at or before this point, unless they have relapsed or deteriorated during that time. The Government will initially set this out as guidance in the Code of Practice, because they recognise that in some circumstances remaining on the CTO may be beneficial to the patient.**

The 2-year rule will have significant unintended consequences and runs counter to the evidence of the effectiveness of CTOs; while they do not benefit the majority of patients there is a sub-group for whom these are very helpful. Insisting that the group who gain the most are arbitrarily taken off these orders at 2 years would be counterproductive and harmful.

The Act should be used only when it is clinically appropriate for the patient. If it is removed due to a statutory time limit and clear evidence is available that this would likely result in relapse and re-detention then this is not the least restrictive option. Guidance in the Code similar to the consideration of a CTO after 7 days s17 leave would be reasonable but anything more prescriptive, which is potentially highly detrimental to an individual’s care, would be ethically questionable.

### **CTOs and the role of the Nominated Person**

**When putting someone on a CTO, the Nominated Person or Interim Nominated Person should be appropriately consulted, with the Act giving them a new power to object, in line with their existing power in sections 2 and 3. As will be introduced for sections 2 and 3, it will be possible to overrule a Nominated Person’s objection to a CTO, without any additional**

**consequence of removing them from that role.**

### **Conditions of CTOs**

**It is also important that conditions made are set out clearly to the patient, to ensure they understand:**

- **which conditions constitute advice (for example about lifestyle choices)**
- **which conditions are required in order for the CTO to be made (for example, about supported living arrangements, or engagement with medicines or other treatment)**
- **which conditions are statutory grounds for recall to hospital (currently, failure to be available for examination so that the CTO can be reviewed, or for examination so that treatment that requires certification to continue can be so certified).Our proposals to update the recall procedure are described below:**

There is no obvious reason for the inclusion of these distinctions. The current situation, which is that additional CTO conditions must serve to ensure medical treatment and to mitigate against the risks associated with relapse, are much clearer. There is no need for “advice” in the conditions if we are keeping them to a necessary minimum.

We do agree with the need to communicate these with the patient in writing and making necessary accommodations, but there may of course be issues of capacity. There is no issue with the existing statutory criteria. However, we think that consideration should be given to conditions explicitly stating the need to comply with treatment and this would not change the fact that it cannot be enforced in the community as recall would still be necessary. It makes no sense that a CTO cannot state “compliance with treatment” on the forms without this appearing problematic.

### **Recalling patients on CTOs to hospital**

**The Government will revise the criteria for recalling service users to reflect our wider changes around detention criteria, so that recall will only be possible when it is needed because there is otherwise a substantial risk of significant harm.**

This is a serious concern. The whole spirit of a CTO is one of proactive treatment and early intervention to avoid repeated lengthy and highly restrictive detentions. It relates to the earlier observation that CTOs are quite dissimilar from sections 2 and 3 and the issues of imminence and degree of illness. The purpose of a CTO is

to maintain treatment to prevent relapse. If this is delayed and the patient is acutely unwell this entirely defeats the purpose of the framework and will be harmful to the patient.

The current wording about likelihood of harm is entirely appropriate and should not be revised. The other issue that applies to both is the way in which very real harms such as distress, vulnerability and profound self-neglect are lost in any dialogue which focusses on self-harm/suicide risk or risk of violence.

## 7.The interface between the Mental Health Act and the Mental Capacity Act

Consultation question 17:

**How should the legal framework define the dividing line between the Mental Health Act and the Mental Capacity Act so that patients may be made subject to the powers which most appropriately meet their circumstances?**

### Summary

In the last review of mental health legislation, there was a recommendation from the Richardson Committee<sup>5</sup> to consolidate mental health and mental capacity legislation, but, after extended discussion the proposal was set aside. This is a frequent debate on the very difficult topic of the MHA and MCA interface. While we know this is not necessarily the place for raising this issue for discussion again, it is important to note that the complicated interface between the MHA and MCA will lead to areas for doubt as to which Act is preferred to maximise autonomy and benefit.

While the legal frameworks remain separate, there needs to be clear guidance on decision-making at the interface of the Acts. This could potentially be provided by the codes of practice. For example, there is a danger that there will not be equity of right of appeal or review of detention between the proposed MHA and MCA and guidance will be required to address this.

The interface between the MHA and MCA has been problematic since the enactment of the MCA, with marked confusion in clinical situations about which legislation is best to use. Until now, if the person meets the criteria for detention under the MHA this is the preferred legislation for clinicians particularly considering the limited options for review of detention under the MCA. It is generally felt that the MHA gives patients more safeguards and facilitates greater access to scrutiny and challenge of detention and hence more protection of their human rights.

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<sup>5</sup> Department of Health (1999) *Report of the Expert Committee: Review of the Mental Health Act 1983*. London: Stationery Office; Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/265574/4480.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/265574/4480.pdf) (accessed 19 April 2021)

Arguably, Liberty Protection Safeguards (LPS) and the MHA review should have been completed simultaneously with a joint approach and guidance on the dividing line. Our patients most commonly fall into the grey area due to the high numbers who have disorders of the brain, such as cognitive impairment, neurodiversity and who lack capacity. It is, therefore, generally the case that when treatment is required primarily for the mental disorder and that treatment is not solely environmental, alongside risk of significant harm to self/ others, then the MHA is applied.

### **Effects of interface on patients with Learning Disability**

If the provisions of the White Paper were enacted, people with Learning Disability would not be defined as having a mental disorder. In the absence of coexisting mental illness, they would not be detained under the MHA and this may have the unintended consequence of an increase in people with LD who lack capacity being admitted to hospital under the provisions of the MCA due to, for example, behaviours that challenge. The provisions for review of detention under the MCA (DoLS or LPS) do not reach the standard of rigour of MHRTs and there would be the risk of erosion of legal safeguards for inpatients who lack capacity.

The proposed legal framework would be likely to impact differentially on people with LD due to the two pieces of legislation that frequently apply to them being reviewed in tandem rather than being brought together as one cohesive piece of legislation.

The additional clinical and legal burdens placed on psychiatrists supporting people with LD by the changes to the MHA tribunal system, and the review system for LPS have been significantly underestimated and are likely to put further pressure on services in terms of recruitment and retention of medical staff.

### **Dividing line between the Acts based on whether patient is objecting to detention or treatment**

The Wessely Review<sup>6</sup> recommended that if the patient objects to admission to hospital then the MHA should be used, while if they do not object then the MCA should be used. This raises further issues which must be addressed:

1. The MCA carries no explicit power of treatment, other than protections against litigation (provided that treatment is reasonably believed to be in the patient's best interests). This means that the patient would be denied the range of protections in the MHA, such as the right to appeal to a tribunal.
2. The only options available to a patient deprived of liberty under the MCA are to ask the supervisory body to review its decision or to appeal under section 21a to the Court of Protection. In our view, the first of these is unlikely to be very effective and lacks independence, while the second is extremely slow and costly. We propose that for patients deprived of their liberty in hospital under the MCA, they should have access to a tribunal system of review analogous to that under the MHA.
3. Clinicians will need to decide if someone is objecting or if their distress is due to something unrelated to detention and could, therefore, be misinterpreted as objection. Would kicking and hitting out at nursing staff during personal care (in people with delirium or dementia) be viewed as objection or not? If someone

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<sup>6</sup> Wessely, 2018.

occasionally spits out their food and spits out their medication as well, is that objection to treatment?

4. Capacity to consent to admission will have to be assessed reliably. Unless there is clarity, there could be potential confusion for teams as to which Act to use and this could lead to multiple assessments and arguments between clinicians, which is not in the best interest of patients.

5. Capacity can fluctuate. This could mean that if the person gained capacity and then decided to refuse treatment, they would need urgent review under the MHA which could be difficult to arrange quickly, for example over a weekend.

6. Patients detained under section 3 MHA in hospital receive the benefit of section 117 after-care free of charge. For patients with long-term conditions requiring indefinite and expensive after-care, such as those with dementia requiring after-care in a care home, this creates a highly unfair structure in which patients who object to their deprivation of liberty in hospital get free care for the rest of their life, while those who do not object are charged for future care under the usual LA charging arrangements. That creates a system in which it is clearly in the patient's interests to make an objection to detention so that they get free after-care. It is not reasonable, fair, or appropriate to base such substantial financial consequences simply on patient objection. This inequality must be addressed.

7. The situation in relation to ECT also needs to be clarified. Currently, some consider that during ECT there is a deprivation of liberty, for example a non-capacitous patient who raises no objection would still need to be made subject to the DoLS regime to be given ECT. Others do not see the period of anaesthesia during ECT as a deprivation of liberty, and do not consider that DoLS authorisation is required if the patient does not object. Some argue, possibly with reasonable justification, that where ECT is in the patient's best interests it can be given under the MCA. However, that deprives the patient of the safeguards in the MHA, for example requiring SOAD authorisation to give ECT to patients who lack capacity.

8. A division between the MCA and MHA on the basis of whichever is least restrictive, would create uncertainty over what that means in practice. Some people think that 'least restrictive' encompasses the effectiveness of safeguards which are usually considered to be stronger in the MHA, while others see the perceived stigma and constraints of the MHA as amounting to a restriction.

Consultation question 18:

**Do you agree or disagree that the right to give advance consent to informal admission to a mental health hospital should be set out in the Mental Health Act (MHA) and the MHA code of practice to make clear the availability of this right to individuals?**

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Consultation question 18a:

**Please provide reasons for your answer**

For many people it will be extremely difficult to properly consider in advance the wide range of circumstances in which they might need to be admitted to hospital for psychiatric treatment in the future. Most people prefer not to think about that

eventuality, and most people lack experience of admission to a psychiatric hospital. If advance consent to informal admission were available, and the patient were treated as a consenting person, then they would be deprived of the protections in the MHA. On the other hand, if it were possible to construct a scheme for protection of such patients analogous to that in the MHA for detained patients then the idea of advance consent might have more merit.

Clinical staff would be unlikely to want to keep someone in hospital and treat them against their currently expressed will or restrict leave on the basis that they consented to it sometime ago. It would also be difficult to know what exactly the person consented to.

The concept has the difficulty that once the patient lacks capacity to revoke a decision about advance consent, there would be no ability to withdraw their advance consent.

Consultation question 18b:

**If agree, are there any safeguards that should be put in place to ensure that an individual's advance consent to admission is appropriately followed?**

There is the potential for this to undermine the MHA, providing less protection in the end and initiating uncomfortable scenarios, such as admitting someone without capacity who is refusing to come into hospital 'voluntarily' because of a previous advance statement. The consequences of this are very complex, for example, if admitted voluntarily the person should be allowed to leave when they like.

For those under 18, and more so for those under 16, there is the additional issue of conflict with the Children Act. This potentially reduces young people's rights in hospital and young people may be at risk of pressure from parents to agree to an informal admission to avoid the stigma of the MHA.

As a minimum it would need to be written, signed and dated, and it would need to clearly state exactly what is being consented to, such as admission and/or treatment.

Given that it could carry serious consequences for the patient in that they could be admitted to hospital and treated, even if they objected at the time (if they lacked capacity), there may be a role for a prescribed form for doing this laid down in regulations, as currently exists for making an LPA. This form should contain information about what is being agreed to and the extent of the authority to detain and treat that is implied.

Consultation question 19:

**We want to ensure that health professionals are able to temporarily hold individuals in A&E when they are in crisis and need a mental health assessment, but are trying to leave A&E.**

**Do you think that the amendments to section 4B of the Mental Capacity Act achieve this objective, or should we also extend section 5 of the Mental Health Act (MHA)?**

- rely on section 4B of the Mental Capacity Act only
- extend section 5 of the MHA so that it also applies A&E, accepting that section 4B is still available and can be used where appropriate

Consultation question 19a:

**Please give reasons for your answer**

We understand this area is of great difficulty. In the spirit of mental health reform, we are wary of endorsing increased coercive legal powers, but there are arguments both for and against the proposal. Extension of section 5 into the Emergency Department (ED) has the potential to facilitate overly coercive practice. However, it also provides an opportunity to 'plug' a legislative gap in the ED to hold patients with mental disorders for whom there is concern about risk of serious harm pending a more definitive management plan that may then include other sections of the Mental Health Act.

Arguments against the proposal:

- The use of a specific holding power in ED for people with mental disorder (or presumed mental disorder) may be discriminatory in restriction of a right to leave.
- Extending a legal power to be more restrictive is not in line with the overall ethos of MHA reform.
- Extension of holding powers does not address the reasons why people may want to leave the emergency department. Reforms should focus on quality of care and creating an environment which is supportive of those presenting in mental health crisis.
- Section 4B of the MCA is worded to be broad enough for clinicians to act where they believe they need to hold someone in order to prevent serious harm (or further serious harm).
- If section 5 is extended to apply in the ED there will then be confusion as to whether to use section 4B of MCA or section 5 of MHA.
- Neither of these powers gives authority to treat, which will remain, as now, a common law authority, with the MCA as protection against litigation for battery where the treatment is provided on the basis of best interests.
- The extension carries a risk of the new holding power being used inappropriately to detain those who wouldn't otherwise fall under the remit of the MHA, including intoxicated people. This could have substantial negative consequences on services.

Arguments for the proposal:

- The MCA is confusing to apply to patients in the ED who make clear that they have suicidal intent and who are being held to await a formal MHA assessment. Extending the powers of Section 5 would be a much clearer framework for 'holding' such patients in the ED.
- The MCA does not apply to children under 16, and while Common Law can be used (and would almost certainly be supported by a Court if later challenged), the MHA would still be much clearer for children and adolescents than Common law. Due to rising numbers of young people

with mental health problems and limited child and adolescent mental health community resources, young people are presenting to the ED in crisis in increasing numbers and current safeguards for this group are inadequate.

It is important that the potential impact on patients of extension of section 5 is considered carefully. The MHA review took views from those who use services and advised against extension. However, this may not represent all potential service user views, particularly those of children and adolescents and their parents/carers. Minimising barriers to seeking help in mental health crisis should remain a clinical and policy priority, which needs to be carefully balanced with the provision of appropriate safeguards for all those seeking mental health support.

Any decision to either continue with the proposal or not must contain provisions to counter some of the potential negative consequences discussed.

## 8. Caring for patients in the Criminal Justice System

Consultation question 20:

**To speed up the transfer from prison or immigration removal centres (IRCs) to mental health inpatient settings, we want to introduce a 28-day time limit.**

**Do any further safeguards need to be in place before we can implement a statutory time limit for secure transfers?**

- Yes
- No
- **Not sure**

Consultation question 20a:

**Please give reasons for your answer**

On the matter of the 28-day time limit (14 x 2 day) for transfer from prison or immigration removal centre to hospital, we welcome the concept of a 'target', but on balance would prefer the Bradley target of 14 days<sup>7</sup>, but not its enshrinement in legislation. Our concerns are mainly about 'unforeseen consequences'. We think there is a substantial risk of avoidance of recommendations for transfer, even in appropriate cases, if there is a perceived penalty against clinicians, health trusts or boards or all of these in the event of a target not being met. Where patients remain in prison beyond such a time frame this almost always results from lack of hospital beds and not from failure of clinicians to respond to assessment requests. At the very least, we think that this requires extended discussion with all interested parties to find a solution that will be an improvement on the current situation. A key recommendation from our patients and carers was that the prisoner designated for transfer and his or her relatives or carers should be given regular information about progress in enacting the transfer.

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<sup>7</sup> Department of Health (2009) The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. London: Department of Health.



Delays are most often due to:

- A lack of available beds in secure service
- Delays in accessing assessment due to high volume/ understaffing
- Difficulty in accessing a specialist secure bed and geographical variation in supply, for example there is no single point of access for brain injury, LD, or ASC beds
- Not all prisons/courts have mental health teams with access to an RC who can complete reports/transfer requests

In order to achieve the 14 x 2 day limit, additional resources and changes to access assessments in particular for specialist secure beds will be required.

Consultation question 2I:

**We want to establish a new designated role for a person to manage the process of transferring people from prison or an immigration removal centre (IRC) to hospital when they require inpatient treatment for their mental health.**

**Which of the following options do you think is the most effective approach to achieving this?**

- *expanding the existing approved mental health professional (AMHP) role in the community so that they are also responsible for managing prison or IRC transfers*
- *creating a new role within NHS England and Improvement (NHSEI) or across NHSEI and Her Majesty's Prison and Probation Service to manage the prison or IRC transfer process*
- ***an alternative approach (please specify)***

Consultation question 2Ia:

**Please give reasons for your answer**

We are in favour of creating a new specialist role to manage the IRC transfer process, but do not think it is necessary for prisons. We separate our response on these two separate areas:

#### IRCs

It should be kept in mind that, although the MHA groups them together with prisoners, immigration detainees are not technically 'patients within the criminal justice system'. There are significant differences between the two groups. Immigration detention is not part of a sentence, is not imposed by a court and does not have a pre-determined duration. Whether or not the detention should be imposed or should continue are questions decided by caseworkers within the Home Office, who weigh up factors in favour of detention (such as any risk of absconding) against factors in favour of non-detention or release (such as any vulnerability or any factors likely to delay removal from the UK).

The purpose of immigration detention is entirely administrative. There is no criminal justice element to it, the detainees are not there to fulfil any societal requirement for punishment, retribution or deterrence. Immigration detention

also has no rehabilitative function. Even foreign national prisoners who are moved to immigration detention are normally moved after they have completed their sentences.

We would be in favour of creating a new role to manage the prison or IRC transfer process. This could be an expanded Approved Mental Health Professional (AMHP) role or an entire new role. We are not in favour of it sitting within HMPPS or across NHSI and HMPPS as it should have a clinical focus.

Given that detention in a non-therapeutic environment (such as an IRC) is a major cause of deterioration of mental health,<sup>8</sup> mental illness potentially requiring treatment under the MHA is clearly a highly relevant factor in the decision whether or not to continue detention. However, lack of awareness of the differences between detainees in the criminal justice system and immigration detainees currently often results in detainees not receiving appropriate treatment in an appropriate setting. The default pathway tends to be transfer as a secure patient under s48 with return to the IRC at the end of the patient's stay in hospital.

Creating a new role to manage transfer from an IRC provides an opportunity to address this by ensuring that there is appropriate clinical input into decisions to detain or release, which would enable the patient to receive the most beneficial treatment in the least restrictive environment.

We, therefore, believe that there needs to be a specialist role, separate from managing transfers of serving prisoners, to ensure that the rights and needs of patients detained under immigration powers can be met and to avoid conflation with the situation of prisoners, who greatly outnumber immigration detainees.

This new expanded AMHP should be involved from the start of the transfer process and ensure that all clinical pathways are appropriately considered in line with the principles of the Act, including treatment in the community, voluntary admission and transfer under the MHA. Throughout the patient's hospital stay and particularly as it comes to an end, they will need to consider the likely impact of return to immigration detention on the particular patient, being mindful of the known deleterious effects of immigration detention, and to consider making a recommendation to the Home Office regarding release and continuing treatment in the community.

In the view of the Royal College of Psychiatrists, IRC detainees identified as needing transfer to hospital for treatment of their mental disorders should be able to appeal to an independent body like a tribunal or a court if the time limit for transfer from the IRC was breached.

In our experience, people with major mental health issues cannot be adequately and appropriately managed in IRC's as the environment itself is deleterious to mental health and frequently precipitates and perpetuates deteriorations.

In our view, mental health tribunal judges should be able to make strong recommendations on immigration decisions, such as return to IRCs, and be able

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<sup>8</sup> British Medical Association (2018), Locked up, locked out: health and human rights in immigration detention.

to provide relevant directions to the Home Office when needed. To support this, we would recommend high quality training on these issues, preferably including input from lived experience practitioners. The additional difficulties for 'failed' asylum-seekers should also be part of the training.

We note that immigration detention affects a particularly vulnerable section of society, and the use of the MHA for this group should be commensurate with the 4 guiding principles of the Act, namely:

- 1) Choice and autonomy.
- 2) Least restriction.
- 3) Therapeutic benefit.
- 4) The person as an individual.

The process of independent and legal oversight of the transfer and return process from immigration removal centres is, therefore, in our view essential in ensuring compliance with the 4 guiding principles of the Act.

### Prisons

We do not understand the concept of 'a new designated role for a person to manage the process of transferring ...' in the context of prisons. The process is already clear; Ministry of Justice officials are invariably helpful if viable transfer options are offered. Clinicians will always offer a bed in appropriate cases if one is available. The limiting step is almost always one of resources, so to expend any new limited funding on a mediation agent seems pointless.

If this role were implemented, it would require the appointment of someone with both clinical and commissioning experience. It may be that a MDT approach would be best rather than a single person, as this would help with prioritisation and liaison with clinical teams, LPCs, NHSEI, MoJ and CJS.

### Consultation question 22:

**Conditionally discharged patients are generally supervised in the community by a psychiatrist and a social supervisor. How do you think that the role of social supervisor could be strengthened?**

We see no need to alter *in law* the role of the social supervisor in preparation for, and after discharge. Social supervisors should, however, be appropriately trained for the task. Further, there should be explicit provision for victim liaison work in the expectation that a social worker who is not employed to work with the patient is available and trained for victim and survivor liaison work. This might be best undertaken jointly with Offender Managers, linking in with MAPPA.

### Consultation question 23:

**For restricted patients who are no longer therapeutically benefiting from detention in hospital, but whose risk could only be managed safely in the community with continuous supervision, we think it should be possible to discharge these patients into the community with conditions that amount to a deprivation of liberty.**

**Do you agree or disagree that this is the best way of enabling these patients to move from hospital into the community?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 23a:

**Please give reasons for your answer**

The proposed power of 'supervised discharge' enabling deprivation of liberty for conditionally discharged patients may appear to offer a path to reduction in restrictions for people who would otherwise be detained in hospital, which would be welcomed. This is also a proposal that would help a small group of patients currently detained under S37/41 who have capacity and who represent an ongoing risk, but respond well to supervision. It is particularly relevant for patients who have neurodiversity, for example brain injury, LD or autism, and would remove a very significant barrier that currently exists in moving these patients from secure care to the community.

However, we are concerned about unintended consequences because of a pressure to discharge people from inpatient services before treatment programmes are completed and could lead to a much larger group being deprived of their liberty in the community for prolonged periods of time.

A new power of this nature also risks being overused (as happened with community treatment orders [CTOs] under the Act) and, unless it is an 'exceptional circumstances' order, then there is the risk of further infringement of a mentally disordered offender's rights even after they are no longer liable to detention. The 'necessity and proportionality' safeguards proposed – which also apply in respect of CTOs – may not be enough to prevent overuse. The proposed risk criterion for this order could easily include every conditionally discharged patient.

An unintended consequence may be that more patients are placed on restriction orders (by the courts, with or without such recommendations from psychiatrists) in order for supervised discharge to be available in the future (psychiatrists may "push harder" for a restriction order to be made).

The option of a supervised discharge may mean that some patients are discouraged from continuing treatment if this would mean that they would have to be in hospital for longer for treatment to be effective. For instance, a patient in a secure unit who actively participates in treatment related work. His MDT assessed that with one or two more years of active nursing, medical and psychological treatment he could be discharged without supervision. Under the proposal, there may be pressure from the patient and/or the commissioners for the patient to be discharged before treatment has been completed, which would mean that the patient is at risk of being on a supervised discharge for a prolonged period of time. This could result in a much more restrictive regime for the patient in the longer-term.

Consultation question 24:

**We propose that a 'supervised discharge' order for this group of patients would be subject to annual tribunal review. Do you agree or disagree with the proposed safeguard?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 25:

**Beyond this, what further safeguards do you think are required?**

We support the provision of an annual review by tribunal. The review process would have to be strong and would need to be thought about very carefully. There would be a need to develop adequate community placements with an increased capacity of community LD teams to support them.

### **Safeguards**

Additional safeguards may include an independent second opinion psychiatrist to review the proposal for supervised discharge who would be expected to give evidence at the relevant (pre-discharge) tribunal.

Patients should only be placed on a supervised discharge if they have been in a hospital with active treatment available for five years or more in order to prevent overuse and to ensure that (in most cases) possible therapeutic gain has been exhausted. Most patients who are currently in this small but significant group of patients who may benefit from supervised discharge have been in hospital for longer than five years.

There is concern that other neurodiverse conditions are not included and that these people may slip through the net – in particular since access to specialist secure services is limited and referral to such services may involve more complex assessment and access – falling close to or outside the time frames. Screening for brain injury will very likely identify many more people in CJS who would benefit from access to hospital. Resources will, therefore, need to follow the legislative changes.

## **9. People with a learning disability and autistic people**

We propose to revise the Mental Health Act to be clearer that for the purposes of the act we do not consider an learning disability or autism to be mental disorders warranting compulsory treatment under section 3. The proposed revisions would allow for the detention of people with a learning disability and/or autistic people for assessment, under section 2 of the Mental Health Act, when their behaviour is so distressed that there is a substantial risk of significant harm to self or others (as for all detentions) and a probable mental health cause to that behaviour that

warrants assessment in hospital. We think this should apply to civil patients only and not to patients coming from the criminal justice system.

**The Royal College of Psychiatrists have separated these questions into two and have given separate answers regarding people with learning disabilities and regarding autistic people.**

Consultation question 26 (Learning Disability):

**Do you agree or disagree with the proposed reforms to the way the Mental Health Act applies to people with a learning disability?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 26a (Learning Disability):

**Please give reasons for your answer**

### **Summary**

In principle, the emphasis on supporting people with Learning Disability (LD) in the community is to be commended but there are concerns about the impacts on these groups that include: complex needs; insufficient time for assessment; definition of mental disorder; inadequate community support; discrimination in support; occurrence of a legal gap and patient and public safety. We understand there is often a lack of sufficient community services to meet the complex needs of people with LD when they are in crisis and hospital admission for care and support is often essential.

The timescale of 28 days to assess mental and physical health is unrealistic in people with LD because of difficulties in understanding the reasons for a complex presentation where psychological, physical and social factors are evident. This behaviour can therefore be conflated with mental disorder.

The proposed reforms discriminate against people with LD where a detailed assessment of the person's needs - delivered safely and aiming to enable the patient to return home - will no longer be available to a proportion of the population as within the legal protections currently enshrined in the MHA.

### **Complex needs**

While we agree with the principle that admission to hospital for treatment should be a last resort for people with LD and that they should not be viewed as mental disorders, unlike other populations, people with LD often present in crisis with very complex needs that include extreme behavioural challenges. Under the proposals, a person with severe challenging behaviour in crisis could not be detained for more than 28 days which may not be long enough to offer effective support and interventions.

### **Assessment**

28 days is not likely to offer sufficient time under Section 2 of the Mental Health Act to assess and diagnose a mental health condition in people with LD as behavioural assessments can take many weeks.

### **Definition of mental disorder**

the needs of people with LD are neglected in the proposals as behaviours that challenge and cause distress in crisis appear to be conflated under mental illness. There is a lack of clarity from the proposed reform on what is defined as a mental health condition. At times, it may not be possible to easily define a mental health condition as the main cause of presentation. In addition, there may be a combination of factors that lead to a person presenting with behaviours that challenge or present a risk to themselves or others.

### **Community services**

Currently, community services cannot manage the level of acuity that people with LD can present with because supported living models are not designed or equipped to provide the constant support and models of care required [Evidence required] .

The principle of detention to assess under Section 2 may lead to improved assessment of comorbidity in those with LD at risk of long-term in-patient care. However, the reforms may lead to people not being detained and - in the absence of adequately resourced social care - may result in people with LD being left in the community without appropriate care and support. This in turn may cause conflict with police and social care services. Furthermore, in the absence of structured hospital care, it is likely that psychotropic medication would be used more frequently in community services, which would be contrary to clinical practice of rationalising and optimising the use of medication [reference/evidence needed] .

As a result, to support the reforms there would need to be a substantial increase in the funding and commissioning of community services for people with LD.

### **Discrimination**

The proposed reforms would discriminate against people with LD especially for those with severe to profound conditions who are unable to access generic services.

They may also lead to a lack of service provision for people with LD who need access to mental health inpatient care.

In addition, they may also result in people with coexisting LD and mental illness having inadequate care. The loss of provisions under s117 to people with LD would also be discriminatory, whereby a person would lose specific entitlements under Section 3, such as the benefits of Section 117 after care arrangements.

### **Legal gap**

The inability to use the MHA for people with LD who display significant behaviours that challenge would leave a legal gap. This could lead to overuse of the MCA which has a less formal review of detention and would impact on the rights of people with LD to challenge detention. The proposed LPS in the amendments to the MCA do not make provision for people who lack capacity and present a risk to others

regarding their deprivation of liberty. LPS will only apply to those who present a risk to themselves.

An unforeseen consequence of not being able to use MHA or MCA is that more people with LD may face arrest when in crisis rather than access care. We note the experience of services in New Zealand where LD was not deemed as grounds for detention. Subsequent legislation had to be enacted in order to offer a legal structure to support people with LD in the community and in inpatient services.

### **Criminal Justice System**

The safety of people with LD would be adversely affected by the inability to detain for care and treatment. Discharge after 28 days is likely to disproportionately cause harm to people with LD. There is a danger that people with LD may disproportionately come into contact with the police and Criminal Justice System if they cannot be admitted to hospital using an appropriate legal framework.

### **Additional resources**

If reforms prevent people with LD staying in inpatient units for long periods under a section 3, it is clear that adequate community provision is critical for this to work.

If these proposals were to be implemented, we request that individuals with a range of neuropsychiatric conditions should be considered within this guidance and it should not be exclusive to LD. Neurodiversity is the agreed terminology for this group of people.

Further, organic personality disorder is a mental disorder and at its core is a set of behaviours that present as challenging and have associated risks. If this is a core feature of the behaviours of, for example, someone with a frontal lobe tumour, brain injury, or fronto-temporal dementia, then we would question how this is different from behavioural challenges due to LD. If the behaviour is a feature of that person's disorder, then they should be afforded the same rights and safeguards of the MHA if they satisfy the detention criteria, regardless of their condition or disability.

Consultation question 26 (Autism):

**Do you agree or disagree with the proposed reforms to the way the Mental Health Act applies to autistic people?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 26a (Autism):

**Please give reasons for your answer**

### **Summary**

We endorse the principle that Autism is neither a mental illness nor a Learning Disability. We therefore agree with the proposal to remove it as a mental disorder



within the meaning of the Mental Health Act. We agree that all the principles within the Act should apply to the treatment of autistic people as they would to non-autistic people. This includes that for autistic people there should be access to essential care and treatment in the community to minimise occasions when admission to hospital becomes essential. Admissions to hospital should follow the principles including least restrictive option so that wherever possible they are on an informal basis. The NHS LTP MH implementation plan is committed to improving community services for all those with mental health conditions and to improving inpatient admission, including having a clear purpose and therapeutic benefit to minimise the length of stay when admission is essential. It is important that diagnostic overshadowing or seeing autism as an exclusion criteria does not prevent autistic people with mental health conditions getting equitable access to such improvements.

We have significant concerns that the consultation refers to people with learning disabilities and autistic people as one grouping, when these are two very different and distinct things (although some people will be autistic and have learning disability). This hampers effective planning, training and evaluation of services and service delivery. We believe that it is essential that the Act and code of practice have separate sections relation to autism and to learning disability. This is in line with modern knowledge and practice as we have moved from the 20<sup>th</sup> to the 21<sup>st</sup> century. The MHA as it stands reflects 20<sup>th</sup> century thinking so it is a timely opportunity to correct that.

We do not believe that simply removing Autism as a disorder within the MHA is sufficient to meet the needs of those autistic people who do not have a mental disorder and we have significant concerns about the wording in the consultation document, which could potentially make things worse for all autistic people.

If Autism is to no longer be a mental disorder within the meaning of the MHA then the criteria for section 2, 3 etc should be the same for autistic people as for non-autistic people. The document, in trying to be helpful, appears to fudge this in ways which will give rise to many practical problems. These are avoidable by a clear statement that detention under MHA for autistic people should require the same criteria as for non-autistic people.

We are concerned that the numbers of autistic people admitted under MHA purely due to autism have not been enumerated and nor has there been any significant review of why these people reach the stage where they are admitted and what might have prevented that. As admission under the Act will no longer be an option for this group, it is essential that the legislative change is preceded by an impact assessment identifying how many people are in this category and what alternative options will be in place for them in future i.e. once the act is reformed. Autistic people, their families and supporters and emergency services all will need clarity on what is the correct option in such circumstances.

This will also be essential if autistic people are admitted under section 2 i.e. for same reasons as anyone else. Some will turn out not to have a mental disorder meeting the criteria for detention within the meaning of MHA and once that becomes clear then the section will cease to be lawful which could be anywhere between 0-28 days from detention. People will need to be clear what is the alternative in such circumstances.

The rise in the numbers of autistic people in MH units will continue as more autistic people are correctly identified. This is not a like-for-like increase compared to 2015 but secondary to the expanding recognition and diagnostic opportunities for autistic people. It is important to distinguish between autistic people getting equitable access to mental health services (which needs to rise given exclusion barriers they have historically faced) and ensuring that autistic people are not admitted simply because they are autistic i.e. that there is another condition requiring inpatient treatment as essential.

As C(E)TRs are not currently fit-for-purpose for autistic people with mental disorders, we are concerned about them being a pre-requisite for admission to a mental health inpatient bed. If they were made fit-for-purpose (which we believe is feasible) then we would support this.

Consultation question 27 (Learning Disability):

**Do you agree or disagree that the proposed reforms provide adequate safeguards for people with a learning disability when they do not have a co-occurring mental health condition?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 27a (Learning Disability):

**Please give reasons for your answer**

### **Summary**

The proposals do not provide adequate safeguards, particularly as there would be a loss of legal safeguards under the MHA and access to support in the community under s.117 aftercare provisions. In addition, 28 days would be insufficient time to ensure a safe discharge; assess the need for and secure an adequate community placement; ensure any co-morbid mental health disorders could be identified and allow adequate treatment for people with LD across all age groups. The proposed reforms may lead to hospital-like care in the community without the safeguard of robust regulation.

### **Assessment**

As previously outlined, 28 days may be insufficient time for co-morbidities to be detected under section 2. The proposal would lead to the risk that mental illness would not be diagnosed and treated.

Under the proposed reforms, the opportunity to undertake full and comprehensive assessments would be limited with adverse consequences for the person and their future in the community.

Assessment for a community placement often cannot be completed in 28 days. Furthermore, the specialist component of in-patient care would not be available in the community. A four-week detention would not safeguard patients' future since

many people require sophisticated planning and resource acquisition that can take months to achieve.

Should these reforms come into force, we would urge that discharge arrangements should start at the beginning of an admission under a section 2 to ensure these are ready by the time the person is no longer detained under the MHA. Ideally these people should have EHCP documents and a CETR to support decision-making during the admission and contain named individuals who can be contacted to support with discharge planning. However, neither of these mechanisms currently guarantee the required resources and often contain a series of recommendations which cannot be fulfilled. This is also the case with many tribunal recommendations for CYP which depend on unavailable resources.

These proposed reforms suggest that presentations of co-existing mental health conditions in a person with LD are easy and clear to define – which is not the case in practice.

### **Missed diagnoses and misdiagnoses**

The reforms are highly likely to lead to the re-branding of challenging behaviour as a personality disorder with the risk of diagnostic overshadowing where symptoms are dismissed as 'behavioural', while the presence of treatable mental disorders is overlooked.

### **Legal Safeguards**

For people who present with very aggressive / destructive behaviours, it is likely that some restriction to their liberty would be required. The MHA offers safeguards and scrutiny more than MCA/DoLS. Currently, as the law stands, patients who continue to present a risk to others in the absence of mental illness will not come under the provision of MCA/DoLS legal framework. Amending the law without providing adequately resourced social care has the potential to put people with LD at more risk, because the protections within the MHA would be removed. If a person with LD were still in hospital and not detained under the MHA, then they would not have access to such safeguards as MHRT, SOAD etc.

### **Community Provision**

Under the proposed reforms, treatment units in the community would have to function similarly to hospitals but without safeguards to protect the individual. This could create difficult situations leading to overuse of medication and restraint in the community. The community units would be de facto inpatient units without regulation. As previously highlighted, community provision would have to be enhanced prior to changing the law.

We note that lack of resources is already a major issue for many children and young people waiting for community services, especially specialised therapeutic/educational placements.

Whether or not these proposals are implemented, we would welcome a greater investment in community services. In-depth assessment and interventions may sometimes be best delivered in a specialist setting with a skilled MDT. Singling out LD for exclusion from the MHA, when other neurodevelopmental disorders

may still fall within its scope, could exclude these particular groups from getting the help they need.

### **Equality / Equity Impact**

Without s.3, there would be no right of access to support and safeguards under S117, CTOs etc.

In community services, children are treated for challenging behaviour and then return home to their families. The proposed changes are likely to cause children and young people to be sent away from their families because of behavioural challenges and not mental disorders.

The worst outcome would be that more people with LD would be in prison. A civil detention might prevent an offence and maybe a longer detention. If the bar is raised, a person would only be admitted to hospital if they had committed an offence. This means more people with LD could be forced to go through the Criminal Justice System to earn a hospital order for problems of aggression.

Consultation question 27 (Autism):

**Do you agree or disagree that the proposed reforms provide adequate safeguards for autistic people when they do not have a co-occurring mental health condition?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 27a (Autism):

**Please give reasons for your answer**

### **Summary**

Given that the proposals say that Autism is not a mental disorder under the MHA then those autistic people who do not have a qualifying mental disorder will no longer be detainable. The proposal in the consultation will not resolve this issue and is a recipe for increasing problems. To protect this group of people there needs to be clarity as to how many autistic people detained under MHA are there currently who this change will apply to, and what are their needs and hence what is the reasonable way of addressing such needs in the future. We are concerned that the consultation has not enumerated these numbers and does not include a formal impact assessment with remedies to prevent adverse impacts from the change in legislation. We believe that the numbers are likely to be small compared to the numbers admitted due to a co-occurring mental disorder but they are often admitted as by time of presentation, admission to a mental health bed has become the default, as no other setting will accept them in that state. We agree that they should not be admitted to MH units if they have no co-occurring mental disorder for which admission is essential at that time, but the proposals fail to give a viable alternative. Such uncertainty will at the very least increase stress for autistic people, their families, supporters and emergency services but is also likely to lead to significant increased harm and/or significant use of criminal justice legislation as

the only viable way of preventing harm. We therefore think it is essential that once the impact assessment is done that viable alternative options are available around-the-clock every day of the year, including any need for specific legislation to cover this.

Consultation question 28 (Learning Disability):

**Do you expect that there would be unintended consequences (negative or positive) of the proposals to reform the way the Mental Health Act applies to people with a learning disability?**

- Yes
- No
- Not sure

Consultation question 28a (Learning Disability):

**Please give reasons for your answer**

### **Summary**

There would be unintended consequences to the proposals. These include inadequate assessment due to reduced assessment time; behaviour attributed to a diagnosis to justify further detention and early interventions could be avoided to gain access to provisions of Part 3 of the Act where there are clear assessment and treatment disposals. As previously stated, implementation of the proposals could lead to significant inequalities between those who have mental disorders and those whose behaviour causes significant distress to them and their carers.

### **Assessment**

The period of 28 days, in many cases, would be too short in clinical practice to complete a full assessment and reach a diagnosis. Often the person requires time to settle from an agitated state in a new environment before any signs of a mental disorder can be elicited or revealed, especially where they have communication difficulties, a complex presentation, or have psychiatric and physical co-morbidities. Furthermore, trusting working relationships between the person and their healthcare professional need time to establish. As a result, important needs could be overlooked and there could be more frequent admissions.

The short assessment period may lead to premature diagnoses because clinicians could feel pressured to ensure patients receive an intervention. The other possibility for detaining patients to prolong the assessment period is inappropriate use of the MCA or LPS. However, LPS only provides for patients who are at risk of harm to self and not to others.

If the assessment period has not allowed sufficient time to fully understand the presentation, premature discharges without an informed intervention plan would likely lead to a recurrence of problems, potentially leading to a cycle of admission and discharge. Similarly, people could be placed in community placements without the staff to support them with their mental disorders.

The loss of s.117 aftercare would also remove provisions such as CTO in the community and financial support to care packages would be reduced since statutory bodies would not be obliged to provide it. This would create further

health inequalities as beyond 28 days, the person will be unable to receive treatment to reduce risk and distress.

28 days of detention may result in unmet needs or a rush to justify detention with a mental illness diagnosis.

### **Criminalising behaviour**

It is possible that people would not receive appropriate interventions until they had offended or caused serious harm to others or property. Consequently, that would risk making criminals of people with challenging behaviours that may be driven by mental disorders, as a longer assessment period would not be available to them under Part 2 of the MHA. People could be stigmatised as offenders but do not understand the consequences of their actions. We need to provide care to people in such circumstances, and not punishment.

### **Inappropriate care provision**

More people would likely be admitted to social care treatment facilities in the community that would not be subject to the same legal supports as would exist under the MHA for an in-patient setting. Social care services would likely be put under pressure to develop such services to support people but there would be a delay between legislation and the provision of viable alternative that would cause further distress. In order to manage distress, clinicians may be pressured into prescribing medication, with particular increases in the community.

If people's needs are not met and risks not managed at an earlier stage, they may enter the mental health system having presented with a much more severe level of risk to self and others than might have otherwise been the case. This could lead to management under part 3 via the CJS which could have been avoided.

Alternatively, the absence of detention under section 3 for ASD may lead to increased use of part 3 to manage risky behaviour that could be managed under section 3 in non-forensic pathways.

These proposed reforms need to be matched with appropriate resource provision. Perhaps if a discharge is prevented due to lack of community services, this should trigger a tribunal to call services to account?

Consultation question 28 (Autism):

**Do you expect that there would be unintended consequences (negative or positive) of the proposals to reform the way the Mental Health Act applies to autistic people?**

- Yes
- No
- Not sure

Consultation question 28a (Autism):

**Please give reasons for your answer**

### **Summary**

Despite the consultation clearly stating that autistic people with mental disorders would come under the same criteria for detention as non-autistic people there are already examples of people giving talks saying autistic people will not be detainable under the MHA or that they will not be detainable under section 3. Whilst clearly preventing autistic people accessing any essential healthcare on the basis that they are autistic would be unlawful discrimination, they already face multiple additional barriers in accessing essential healthcare. It is therefore essential that the guidance and reformed act make it explicit that detention for autistic people should be on the same criteria as for non-autistic people.

There is a risk that people will not see the need for reasonable adjustments and person-centred care for autistic people meeting criteria for detention under MHA on the assumption that they will not be admitted. As mental health conditions, including serious mental illnesses, are much commoner in autistic than non-autistic people this will not be the case. In the same way that the code of practice looks at other groups where specific adjustments might be required to services (e.g. ethnicity), we believe it is essential that the code of practice continues to specifically emphasise the need for reasonable adjustments for autistic people admitted to MH units and hence it should have its own section in the code of practice.

We have noted earlier that there is a significant risk of autistic people without mental disorder becoming “turnaways” from all services despite significant distress and risks. This will be a tragedy for all concerned.

We believe that without reforming C(E)TRs to make them more appropriate for autistic people with mental health conditions where admission is essential or very close to being essential that they will simply function as added bureaucracy with no benefit to outweigh this. As noted we believe this can be avoided through specific reforms to the process to make it more efficient, more effective and more timely.

We believe that one positive outcome, whether direct or indirect, through the impact assessment could be to build on the developing knowledge of what can improve life for autistic people in the longer-term post-diagnostic phases (i.e. not just immediate post-diagnostic support). At present access to support through Care Act or through health or other routes is very limited and very patchy. There is often inadequate understanding of autistic people, particularly adults and older adults without learning disability and how they present and how their needs vary. In particular, dedicated sub-regional autism hubs (integrated across health, social care and third sector) and with regional/subregional autism teams able to advise, educate, train and support generic services and with the ability to provide specialist augmentation to the generic service input when this is essential.

Consultation question 29 (Learning Disability):

**We think that the proposal to change the way that the Mental Health Act applies to people with a learning disability should only affect civil patients and not those in the criminal justice system. Do you agree or disagree?**

- *strongly agree*
- *agree*
- *disagree*

- *strongly disagree*
- *not sure*

Consultation question 29a (Learning Disability):

**Please give reasons for your answer**

### **Summary**

The existence of different definitions of mental disorder would be open to legal challenge. The proposal would not provide sufficient time under s.2 to fully assess patients and to clarify the issues related to mental disorder and criminal behaviour. The proposals are likely to result in more people with LD receiving punishment in place of care. They are likely to spend longer in prison as prison and probation services are not equipped to support their needs. The proposals would create a two-tier system where the criminal justice route with diversion to offender mental health services would lead to assessment and treatment, compared to the civil route which would not.

We support the same definition of mental disorder being used in Part 2 and Part 3 to avoid discrimination and disadvantage in care to people with LD.

### **Definition of mental disorder**

Having different definitions of mental disorder between Part 3 and other parts of the Act would mean it would be open to legal challenge. It is difficult to justify why LD should be part of criteria under which someone could be detained if they have committed an offence but would not be if the person caused harm to others but lacked criminal responsibility. Conversely, if the view is that people with LD should be dealt with by the criminal justice system on a similar basis as the general population, then we would ask why people with LD should be included in Part 3 of the MHA.

### **Assessment (length of assessment)**

If the current proposals only apply to civil patients, it is unclear how the gap between a detention under Section 2 and the outcome of criminal justice processes would be managed. A Section 2 is unlikely to allow sufficient time for an adequate assessment to be made in relation to fitness for trial, criminal responsibility, or response to treatment in the context of serious offending. Section 2 would not be sufficient for the necessary assessments to be completed for final sentencing recommendations.

### **Legal safeguards (loss of safeguards; MHA/MCA)**

This proposal would likely lead to increased criminalisation of people with LD. If ongoing detention under Section 3 is no longer possible, and there is a risk of violence towards others, the only framework within which people could be detained and have access to services (such as Sec 117 provisions) would be through the Criminal Justice System.

This proposal would lead to a discriminatory 'two-tier' system. Whether someone is managed within the Criminal Justice System or not could become arbitrary, or based on local provision and practice within certain areas. People displaying similar behaviour could be managed differently depending on what local diversion schemes are available, the local resourcing of community services, and local clinical



expertise. In areas where there are limited community services, more people would go to prison if civil detention was no longer an option.

### **Community provision**

We are concerned at the potential impact on vulnerable individuals who engage in persistent property damage and assaults on social care staff. The police are often reluctant to press charges and community services may not be willing or able to continue to provide support. With the current proposals, it is unclear what frameworks or services would be available to ensure vulnerable individuals receive the care required while the risk posed to others is managed.

Individuals with LD who engage in serious offending behaviour have complex needs and require specialist multidisciplinary input. To appropriately support individuals within the community, community services need to be adequately resourced to ensure stable staff teams with strong links to the wider multidisciplinary clinical team. The current proposals to legislative change do not address this lack of provision.

### **Equality / Equity impact**

This proposal is likely to lead to more people going to prison or spending longer periods of time imprisoned due, due to not meeting probation requirements and/or the lack of suitably adapted treatment programmes within prison. Unless significant investments are made to the prison environment to provide physical environments and treatment programmes suited to people with LD, these groups would be vulnerable and disadvantaged within the prison setting.

This proposal would lead to a discriminatory 'two-tier' system. Having different definitions of mental disorder between Part 3 and other parts of the Act would be open to legal challenge.

### **Criminal Justice**

We understand some of the concerns and pressures behind the stated intent to remove LD from the cluster of mental disorders within the scope of the Mental Health Act. We have major concerns, however, about unforeseen consequences. The rejection of the idea that a very serious disorder of brain and mind that affects health, wellbeing and functioning is a mental disorder has a consequence for people whose conditions are still regarded as mental disorders. This suggests either stigmatisation of people with other mental disorders by denial of association and/or that the disorders may not be understood or treated within a physical or medical framework.

Our further concern is about the illogicality of treating people differently in this respect in the event of offending behaviour. The prospect of leaving people with LD in prison because there is no alternative is concerning, but so is the risk of leaving people unattended until they offend.

Some patients may be left in unsafe environments as no placement is available in the community. In these circumstances it could increase the likelihood that people would be charged with some social order offence as this could be seen as the only safe alternative. For instance, a young man with mild to moderate learning disability living in a care home who repeatedly touches members of staff

inappropriately. In such a case the police may have to arrest and place them in custody if a hospital bed is not available.

This may ultimately lead to an increase of the number of people with LD in prisons, and we know that these groups are often not recognised (or appropriately referred) if they are in prison.

Insofar as new legislation is required in this area, it seems to require legislation in favour of provision of a wide range of community services. A new duty on local commissioners to provide health, social and educational services according to need is a step in the right direction. Nevertheless, it may still arise that all appropriate community services have been explored and the person's health and wellbeing remain at risk.

Consultation question 29 (Autism):

**We think that the proposal to change the way that the Mental Health Act applies to autistic people should only affect civil patients and not those in the criminal justice system. Do you agree or disagree?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 29a (Autism):

**Please give reasons for your answer**

### **Summary**

It is not logical to say that autism is not a mental disorder within the meaning of the MHA but it becomes one if an offence is committed. Autistic people are in general more given to logical thinking and consistency in rules and application of rules than non-autistic people. Such an illogical arrangement will therefore cause considerable stress and confusion.

People admitted to forensic units typically have vastly longer lengths of stay than for those admitted to acute mental health units. So, if the intention is to reduce length of stay in hospital this proposal will be self-defeating.

It will result in many more people being diverted into the criminal justice route with the costs to the individuals, their families, services and society following on from that. This will be especially likely if the impact assessment discussed earlier has not been carried out or the necessary provisions put in place. If the only way of accessing services is by breaking the law then more people will do so accidentally or deliberately as nothing else available to give a better alternative.

So logically and practically this does not make sense i.e. if autism is not a mental disorder under MHA it is not a mental disorder under MHA so detaining people on grounds of autism under MHA should not be lawful under any section of MHA

Consultation question 30 (Learning Disability):

**Do you expect that there would be unintended consequences (negative or positive) on the criminal justice system as a result of our proposals to reform the way the Mental Health Act applies to people with a learning disability?**

We are concerned about significant and negative unintended consequences of this proposal. The negative outcomes would affect people with LD as well as increase public safety concerns. The proposal suggests priority for punishment rather than care. Diverting people to the Criminal Justice System because it would be the only route through which to gain access to treatment, would lead to greater mental health impacts on already vulnerable people. The capacity of prisons and offender services would be stretched, even overwhelmed in attempting to support and process more people with LD presenting with behavioural problems. Serious offences such as sex offending and fire-setting that could be managed under civil sections would pose greater risks in the community where the option of treatment in hospital under a civil section was not available. In the absence of treatment, offenders would be inappropriately remanded to social care settings and to family care rather than diverted to health settings for therapeutic interventions.

### **Assessment**

We are concerned that the proposal would lead to increased criminalisation, and increased use of Sec 37 and Sec 37/41 leading to longer-term hospital care and additional restrictions for those subject to these measures.

If more individuals with LD are sent to prison rather than to forensic LD in-patient settings, they will not be provided with the highly specialist multidisciplinary treatments that will help to mitigate the long-term risk posed to others. Without the underlying risk factors being effectively addressed, further offending on release from prison is more likely. The risk posed to the public would include serious sexual offending and physical violence.

### **Legal safeguards**

As noted in Question 4, this proposal would lead to a two-tier system with arbitrary outcomes for similar behaviours. If civil detention beyond Section 2 is no longer an option, public safety concerns would be likely, due to the lack of a framework within which to manage behaviours that pose a risk to others. The changes to the MCA may be necessary to include risks posed to others, not just risk to self.

This proposal would lead to the loss of important safeguards such as Sec 117 aftercare.

### **Community provision**

This proposal would lead to increased pressure on the Criminal Justice Service to divert to community services, where there are insufficient resources to meet the needs of this complex group. There are also significant concerns about how community services would manage behaviours that pose a risk to carers.

### **Specialist provision**

More requirement for specialist secure / locked door services, and better diversion at point of access to CJS, is required. Better investment in prevention strategies should also be prioritised. Furthermore, people with diagnoses other than LD, will

be excluded, so training in screening and diagnosing neurodiversity should be required for all CJS providers.

### **Equality / Equity impact**

Unless there are plans to have a hospital wing for people with LD in prison with the right treatments and skilled staff, it is difficult to see how prisons would cope. It is also unlikely that any adequate end-to-end service could ever be put in place within the prison setting. The length of stay within custody is also likely to be longer due to an inability to meet probation requirements or complete treatment programmes that are unsuited to the communication needs or cognitive level of people with LD.

### **'Forensicization'**

If the mental health needs and risks of people with LD are not managed at an early stage, due to exclusion from detention under section 3, they may enter the mental health system having presented with a much more severe level of risk to self and others than might have otherwise been the case, leading to management under part 3 via the CJS which could and should have been avoided. Alternatively, the absence of detention under section 3 for LD may lead to increased use of part 3 ('forensic sections') to manage risk behaviour that could presently be managed under section 3 in non-forensic pathways.

[Consultation question 30 \(Autism\):](#)

**Do you expect that there would be unintended consequences (negative or positive) on the criminal justice system as a result of our proposals to reform the way the Mental Health Act applies to autistic people?**

Yes, a clear unintended consequence will be that a key incentive to provide better community services for autistic people will be lost if autism is simply dropped as a mental disorder within the meaning of MHA without the impact assessment and clearly identified and funded alternatives.

As noted, this means that an unknown number of people will then not receive what they need until they have deteriorated to point where things have gone catastrophically wrong which will often bring them into the remit of the criminal justice system. For autistic people who already face multiple additional access barriers to receiving care and help then they are more likely to end up in catastrophic meltdown posing significant threat or actual harm to self or others, and if the only response is via police and criminal justice system that is where they will end up. This is not to the advantage of anyone and defeats the whole purpose of the MHA reform principles.

Non-custodial outcomes will become much more difficult to support if autistic people do present to criminal justice system as a result of a crime leading to either more people in prison or in secure services and for longer. In particular, if peoples presenting behaviours have to reach criminal justice levels to get help then much it is more likely community support systems and families will be exhausted and burned out.

Clearly all of this increases risk to the local community and will in turn reinforce stigma against autistic people in the local community.

We know from work on mental health care pathways and flow that the later an issue is addressed the more likely it is to become chronic, the more likely that secondary and tertiary disabilities and/or illnesses will occur, and the more likely admissions will be prolonged and are more likely to lead to restrictive interventions. So even if an autistic person then goes on to develop a mental health condition in custody requiring transfer to a mental health bed, they are likely to be in a much worse state.

As noted, it will also create multiple issues for autistic people and their families if autism is not a disorder under MHA but then becomes one once a crime is committed. This is not logical and will not make sense to anyone, including those most affected, autistic people. A key aim of MHA principles is using least restrictive approaches. It is extremely difficult to reconcile a recommendation that will drive up custodial sentences or stays in secure inpatient units as being compatible with such a principle.

Consultation question 31 (Learning Disability):

**Do you agree or disagree that the proposal that recommendations of a care and treatment review (CTR) for a detained adult or of a care, education and treatment review (CETR) for a detained child should be formally incorporated into a care and treatment plan and responsible clinicians required to explain if recommendations aren't taken forward, will achieve the intended increase compliance with recommendations of a CETR?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 31a (Learning Disability):

**Please give reasons for your answer** (up to 200 words).

### **Summary**

We agree that CETR can be very beneficial in avoiding hospital admission, facilitating discharge from in-patient services and in engaging commissioners in the process of supporting people in the community. However, it is also the experience of psychiatrists that CETR can be unnecessary barriers to the delivery of care, especially where responsive admission is in the best interest of the person but cannot take place without it being recommended through the CETR process. Giving more weight to CETR recommendations could be extremely problematic as the recommendations are not always helpful. We suggest that recommendations of CETR should be considered by clinical teams for incorporation in to care plans, but not something that should be mandatorily required.

### **Accountability**

We understand the principle of incorporating recommendations in to care plans but have great concern about the competence of the members of CETR panels

who are not accountable for the decisions they take. If the recommendations were obligatory, the panels would have to be accountable, and regulation would have to be in place to support the process.

If the recommendations were to be made statutory there should be safeguards such as a requirement for legal professionals (as in Mental Health Review Tribunals), or at minimal someone who has the authority to challenge decisions. If they were set on a similar footing to MHRTs, then something with equivalent status to 'Recorded Matter' as used in Scotland may be useful (i.e. something with the intention to ensure the provision of appropriate services for individual service users where a specific need has been identified)..

### **Services**

In addition, failure to implement CETR is often due to problems with the ability of Local Authority and/or education to provide services under their responsibility. Making the mandate stronger will not have any effect if the services are not available.

In practice the CETR process serves the function of a CPA meeting, the utility of which has been eroded due to long term cuts and increased demands on services. The 'fix' of the CETR would not be necessary if existing mental health and social care services were adequately resourced and supported.

### **Responsible Clinician**

The role of the responsible clinician is designated under the MHA legislation to which the CETR process is not subject. A psychiatrist is not always involved in the CETR process and therefore the Consultant Psychiatrist should not be apportioned responsibility for implementing tasks that are out of their clinical responsibility. If formalised, a mechanism to consider disagreements to the recommendations would be required before they were formally incorporated into a care plan.

This proposal undermines the expertise and standing of RCs and the treating team, and introduces formidable additional reporting requirements in situations of disagreement. It will make working conditions more stressful, erode morale, and exacerbate the recruitment and retention crisis in psychiatry.

### **Increased bureaucracy**

This proposal significantly increases the bureaucratic complexity, time and cost of provision of care for people with LD. It is a bureaucratic solution to underfunding of services, which will increase costs without addressing the underlying systemic resource problems impeding effective health and social care.

It increases the risk of 'decision paralysis', whereby the provision of care in a timely manner is prevented by bureaucratic complexity and situations where there is substantive disagreement between the views of the RC and treating team and those on the CTR/ CETR panel.

Consultation question 31 (Autism):

**Do you agree or disagree that the proposal that recommendations of a care and treatment review (CTR) for a detained adult or of a care, education and treatment review (CETR) for a detained child should be formally incorporated into a care and treatment plan and responsible clinicians required to explain**

**if recommendations aren't taken forward, will achieve the intended increase compliance with recommendations of a CETR?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 31a (Autism):

**Please give reasons for your answer** (up to 200 words).

**Summary**

A good quality timely C(E)TR can be very valuable but the reality for autistic people is that they frequently do not work for a number of reasons:

- They are often not timely (e.g. commissioner has 28 days to arrange one – median length of stay in an MH inpatient ward in England currently 28 days),
- frequently the experts both by training and experience are experts in LD not in autism and often have very limited knowledge of mental illness or mental illness services,
- often requests for reports and information based on LD documentation not what is useful in mental health so creating need for additional reports and documentation which simply further reduce time clinicians have to deliver clinical care.

The direction of travel in mental health services is “easy in easy out” i.e. get person into hospital rapidly when essential with clear purpose and delivering this quickly to get the person out again quickly so delaying this to arrange for more meetings is not helpful.

Often requests for C(E)TRs involve long delays and then do not happen or get cancelled anyway.

We believe that the first step is to get C(E)TRS streamlined and effective for autistic people so that if they can suggest something that can be rapidly delivered to mean admission is no longer essential either before or early in the admission this is done with minimum of added bureaucracy. If they cannot then they should still take place even if person has been discharged by then to look at what might help prevent a further admission. We believe these reforms to the system are feasible and sustainable.

If that is done and C(E)TRs recommend things that are viable and deliverable in a timely manner, then it might be appropriate for them to become built into care plans as long as waiting for that recommendation to be delivered does not lead to a delay in the person being admitted/discharged. Clinicians often do not have the power to carry out the recommendations (as often these will entail the commissioners making additional resources available) so it is important that the clinician is not held accountable for things outside the clinicians control – the proposal does say the responsible clinician is required to explain why recommendations were not taken forward so on paper it looks as though they can

explain any which are out of their control but that is not how clinicians perceive the reality. They perceive that they get blamed for things that they did not recommend and have no control over delivering.

Consultation question 32 (Learning Disability):

**We propose to create a new duty on local commissioners (NHS and local government) to ensure adequacy of supply of community services for people with a learning disability. Do you agree or disagree with this?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 32a (Learning Disability):

**Please give reasons for your answer**

### **Summary**

Within the proposal, we agree that local commissioners should have a duty to ensure adequate community services. However, it would require a serious and sizeable commitment to resourcing of both community services and training of community staff. The use of the term “adequacy” needs to be defined as there is a concern this could be quantity rather than quality of services. Provision of funding to provide good quality community service options should happen prior to the MHA changes being implemented.

We are concerned that 28 days under a s.2 MHA would give little time for assessment, formulation, treatment, and time for local commissioners to identify an appropriate community service(s) to meet the needs at discharge with the option of people returning to services that could not support them effectively.

“The real reason for prolonged admissions which lies at the heart of these reforms is the lack of adequate community services, changing the MHA in my view is a red herring and won't change this fundamental issue”.

### **Community services**

There continue to be inappropriate admissions to inpatient services when behaviours have escalated to the point of threshold for admission (presumably could be referred to as ‘distressed’ under new measures) because of a lack of suitable community support (i.e. inappropriate environment, lack of specialist knowledge or training, or a placement not able to meet the needs of an individual).

In effect, risk to self or others has escalated to an unsafe level and responsibility is transferred from LA to CCG to admit due to unmanaged risk with the danger of inappropriate, traumatic and delayed discharges with little therapeutic effect.



Hospital resources must match the level of community resources required with the increased statutory systems outlined in the proposed changes to the MHA. There will be other community service changes required: robust crisis service teams and full MDT community teams particularly with specialist behavioural psychology for people with autism.

There is a concern that the 28 day s2 assessment will not be long enough to procure appropriate accommodation, care packages and effectively transition the patient to the community.

Consultation question 32 (Autism):

**We propose to create a new duty on local commissioners (NHS and local government) to ensure adequacy of supply of community services for autistic people. Do you agree or disagree with this?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 32a (Autism):

**Please give reasons for your answer**

This is essential to improve services to autistic people (and their families/carers when such exist).

The potential problem with this duty is that it is so loosely defined that it could be meaningless. It needs to have a working definition of what adequate means to be useful. This may be the intent and may be covered in secondary legislation but if it is not done well it could just enable commissioners to say we have met the minimum standard so job done. We are aware that many autistic people struggle to get a care act assessment currently and even fewer get any support or services following a care act assessment. Often the decision whether to assess and/or the assessment are carried out by people with little knowledge or training in the presentation and needs of autistic people, often involve phone triage which directly discriminates against autistic people and often score the person on their best level of functioning not the realities of their functioning. Therefore, we strongly support the principle but a lot of work to do to make it effective and sustainable.

Consultation question 33 (Learning Disability):

**We propose to supplement this with a further duty on commissioners that every local area should understand and monitor the risk of crisis at an individual-level for people with a learning disability in the local population through the creation of a local 'at risk' or 'support' register. Do you agree or disagree with this?**

- *strongly agree*

- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 33a (Learning Disability):

**Please give reasons for your answer**

### Summary

We feel this proposal would drive proactive contingency planning which would help to reduce crisis presentations and so reduce risk of avoidable compulsory admission for people with LD.

We make the following suggestions for ensuring the success of the proposal:

- The term 'dynamic support register' instead of the suggested terms.
- Registers should be monitored and linked to enhanced personalized funding to support the individual but not at the expense of others. People on the register should receive enhanced, personalized funding to support their community. In some areas registers already exist but they are not effective unless "something is done with the register".
- A register may be perceived by some as stigmatising or labelling people with complex needs and as "one step towards admission". Will the individual or their parents/carers give their consent for their name to be added to the register? Who would decide who would be on the register and what would be the registration criteria?
- There should also be active monitoring and engagement with the family and professionals together with a plan, as a register by itself will not achieve anything. Currently many such CYP still fail to receive an EHCP so this will also need additional SEND resource.
- There must be adequate and appropriate staff to support people in the community to reduce the risk of patients needing to be added to a risk register.
- Cross organisation sharing of patient information is already difficult due to individual organisation information sharing policies. This will need to be revised to ensure an adequate level of information sharing to manage and reduce risk and the need to go on the register. National guidance will be required in line with existing data protection guidance for health and social care organisations. This is particularly relevant for risk register discussions when the patient is cared for under one statutory and particularly for transition cases under children's services.
- Risk registers will only work if relevant professionals meet and focus on how to resolve the problems which bring patients onto the register and solve problems to move them off the register.
- Patients should give their consent to being placed on the register and their information being viewed or discussed with professionals outside of their MDT.
- An evidence base is required for best practice for risk register meetings.

Consultation question 33 (Autism):

**We propose to supplement this with a further duty on commissioners that every local area should understand and monitor the risk of crisis at an individual-level for autistic people in the local population through the creation of a local 'at risk' or 'support' register. Do you agree or disagree with this?**

- *strongly agree*
- *agree*
- *disagree*
- *strongly disagree*
- *not sure*

Consultation question 33a (Autism):

**Please give reasons for your answer**

### **Summary**

We have concerns that this could discourage autistic people getting diagnostic assessments. We know from feedback and research that such assessments are, in themselves, very important and helpful to the person. We know that multiple disadvantaged groups including but not limited to certain ethnic communities, are more likely to face access barriers but we do not require all people from ethnic minorities to sign on to a register with the local commissioners.

We have already noted that many autistic people struggle to even get care act assessments.

For autistic people under learning disability services that will be dealt with in the Learning Disability response.

Autistic people who do not have learning disabilities may be receiving no ongoing service. We know that many remain anxious about being public about being autistic due to continuing stigma and discrimination against autistic people.

For autistic people where mental disorder is a factor or suspected factor in the impending/actual crisis there are 24/7 crisis access services for mental health which can both triage the concern and link the person into services. These really only became nationally operational in April 2020.

People under specialist mental health services will be stepped up to intensive home treatment if at risk of hospitalisation in line with NHS LTP MH implementation processes. This includes autistic people receiving such services. Timely access to integrated care and treatment at such times is more important than creating a register.

On the other hand, if the register was a voluntary opt in one i.e. people who chose to, could go on it especially if they have or are likely to reach point where crises will occur whether they are under services or not then that would be a good thing as long as it was actually going to release necessary resources in a timely way to make a beneficial difference. Although do not over promise and under deliver is a general

principle it is even more critical with autistic people who are more likely to take things literally and to expect that what was promised will deliver. Failure to do this actually increases the risk of crisis and/or of crisis spiralling into catastrophic meltdown and/or significantly greater risk they will not engage with services in the future.

So, if it is voluntary, if it will set out clearly what it will deliver and then will actually deliver this when needed in timely manner then it will be a useful adjunct to care and treatment services especially for those who do not have LD or serious mental illness and so will be less likely to be receiving supports through those routes.

Consultation question 34 (Learning Disability):

**What can be done to overcome any challenges around the use of pooled budgets and reporting on spend on services for people with a learning disability?**

**Summary**

We support any move to promote and enable closer working between health and social care that would result in improved services for people with LD. Greater integration between health and social care is to be welcomed but there are concerns that pooled budgets in isolation might not be the solution since they require the appropriate infrastructure to support them.

The challenge to pooled budgets is the absence of integration of health and social care systems. We are concerned about how funds could be fairly divided between health and social care given the pressures on both services and the need to expand community provision in the light of the recommendations of this white paper. The financial burden of section 117 aftercare needs to be examined when considering pooled budgets.

The greatest challenge is to develop excellent services and infrastructure to support people with LD. A report on spending on LD services would be welcomed to evidence that the spend on health and social care is appropriate and proportionate to the needs of the LD population. Changes must be accompanied by changes in workforce and commissioning.

**Service infrastructure**

In considering pooled budgets, the major legal concern is the management of s117 aftercare. The under-funding of health and social care and some of the inequalities in those funding streams was identified as a challenge to pooled budgets. It was noted that attempts to pool budgets in the past with integration between health and social care were unsuccessful, however we broadly welcome anything that would foster better working between health and social care. To successfully pool budgets the relevant infrastructure to support the process would need to be in place. Some of our members have expressed their feeling that monies are not the main problem and the need to develop services and infrastructure was the priority (which also requires funding).

**Integration of services**

In community service provision, we would highlight that pooled budgets should not be the sole solution and that they in isolation might not be effective in the absence of properly integrated health and social care services. It was identified that in many areas, health and social care do not work as integrated teams and that differing priorities between these services do not always support the principles of integration. It was also considered that there are too many boundaries for health staff to work more closely with colleagues in social care and education.

There is concern that there could be a gradient of funds flowing from health to social care. In addition, in older adolescents and young adults tripartite funding with education would confuse the picture further.

The absence of fiscal and service planning for certain groups e.g. young adults and taking decisions on a case-by-case basis is a challenge to pooled budgets.

### **Systems planning**

The current system responds on a case-by-case basis rather than planning for groups of people and the recommendation for a person to be closer to the family home needs to be balanced against meeting the person's requirements. Pooling budgets could work but would need to be complemented by changes in commissioning and workforce planning.

Consultation question 34 (Autism):

### **What can be done to overcome any challenges around the use of pooled budgets and reporting on spend on services for autistic people?**

#### **Summary**

We support the move to integrated working and “no wrong front door” as key principles underpinning the NHS LTP and likely to be key principles in the replacement to Think Autism.

One key lesson which was learned from closure of the mental health asylums is that when money went out with patients it often then disappeared when those people moved on/died. Some of this went into meeting the overall social care budgets and the reductions in those over the years and a lot of it in to supporting acute hospital overspends. This then meant that as more people came through who needed access to the services/funding used to move people out of the asylums it was no longer there. This has directly contributed to the under capacity of community mental health services and thus directly to things like very high acute MH bed occupancy, out of area beds having to be used, increased numbers of new long stay in (often) very expensive out of area long stay provision (whether called rehabilitation or anything else) and the rising numbers of people ending up in forensic services.

So, we welcome any increase in social care funding (and indeed we believe that this is essential to improving services) and we welcome increase in the LTP health funding and we believe that the public monies should be used to achieve best

value. We are mindful that not learning from the mistakes of the past could simply lead to repetition of the same and less not more funding being available for autistic people. We therefore recommend transparency of funding and spend and clarity that any shared or pooled budgets do not allow seepage away of the resources. If that can be addressed in a robust manner, then we think integrated approaches to health and social care will be much enhanced to the benefit of autistic people. There are opportunities such as Autism Hubs on which to build integrated services across health, social care and third sector services and we commend such models.

## **11. The experiences of people from black, Asian and minority ethnic backgrounds**

Though the White Paper Consultation does not ask any questions on specific issues on race and equalities, we would like to take this opportunity to express our views on this area.

We are heartened that the White Paper in accord with The Wessely Report, which was clear that a 'combination of unconscious bias, structural and institutional racism, which is visible across society, also applies in mental health care.' It details the specific ways the Government aims to carry through the recommendations of this report by tackling the structural issues of racism in society and the mental health arena.

The Government are investing in a variety of ways to tackle these issues. The White Paper specifically details a variety of ways in which the Government aims to tackle the structural, institutional, cultural, historical and process-driven discrimination that BAME people can suffer, and specifically in the mental health sphere. These include: the development of the Patient and Carer Race Equality Framework (PCREF), currently being piloted with plans to roll out further; culturally appropriate advocacy; and ways to support people of Black African and Caribbean heritage rise to senior levels of all mental health professions, especially psychiatry and psychiatric research, psychiatric nursing and management. All these programs are of great importance to tackling the issues that exist.

The COVID-19 pandemic has had devastating effects on ethnic minorities and is widening further the health inequalities that exist. Further to this, COVID-19 is beginning to cause an enormous surge in mental health crises across the entire population.

This, if unchecked is likely to lead to a rise in the involuntary detention of people of all races under the MHA and it will be essential to tackle the structural issues at play to avoid the vast potential consequences on public health at enormous financial cost. The societal cost of health inequalities to individuals and groups is continued lack of cohesion and the economic costs arising from the welfare burden; healthcare costs and the lack of productivity are estimated to be in [the region of £57 billion per year in England](#).

## Part 2

### The role of the Care Quality Commission (CQC)

Consultation question 35:

#### **How could the Care Quality Commission support the quality (including safety) of care by extending its monitoring powers?**

- More data on the use of the MHA among young people including outcomes would help children and young people, their families and clinicians make more informed choices.
- Review of tribunal processes for children and young people and those with LD to ensure developmentally appropriate standards.
- Need to ensure that children and young people and their families get access to the right support and information regarding current and future care, and any associated long-term implications – to be able to make the right decisions, ask the right questions and get the right support.

### Impact assessment

Alongside the White Paper, we have produced an [impact assessment](#) in which we have estimated the likely costs and benefits of implementing the proposed changes to the act.

Consultation question 36:

#### **In the [impact assessment](#) we have estimated likely costs and benefits of implementing the proposed changes to the act. We would be grateful for any further data or evidence that you think would assist the departments in improving the methods used and the resulting estimates.**

**We are interested in receiving numerical data, national and local analysis, case studies or qualitative accounts, etc that might inform what effect the proposals would have on the following:**

- different professional groups, in particular:
  - how the proposals may affect the current workloads for clinical and non-clinical staff, independent mental health advocates, approved mental health professionals, Mental Health Tribunals, SOADs etc
  - whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered
- service users, their families and friends, in particular:
  - how the proposal may affect health outcomes
  - ability to return to work or effects on any other daily activity
  - whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered
  - any other impacts on the health and social care system and the justice system more broadly

Please provide information. You can also upload files when you [respond to the consultation](#).

These proposals would require a significant increase in resources and provisions at all levels of mental health services as well as for local authorities.

Specifically, Tribunals, SOADs, Advocacy services will need substantial expansion. Inpatient and community mental health services will need more resources because the proposals will generate increased activities. Local authorities will need more resources to commission more suitable community placements for people with learning disabilities and autism.

It is already very difficult to recruit to many areas of psychiatry – we are concerned that the extra administrative burden will take away from direct clinical time with patients and make recruitment more difficult, especially as there seems to be a trend towards reducing administrative support. We would therefore recommend an essential workforce planning element to the impact assessment, including an action plan for recruitment and retention to inpatient units.

## Workforce

Between 2016/17 and 2017/18, detentions under the Mental Health Act increased by 2.4%.<sup>9</sup> There was a further increase of 2% in the year to March 2019<sup>10</sup>, with a further increase of 0.8% in the year to March 2020 (when using the same methodology).<sup>11</sup> This is at a time when there are already pressures on the workforce, with high vacancy rates across mental health trusts and shortages of specialist staff. Our most recent census in 2019 found that one in ten psychiatry consultant posts were vacant.<sup>12</sup> The most recent data from NHS Improvement, which covered the fourth quarter of 2018/19, [showed a total of 20,440 WTE vacancies across the mental health workforce, equating to 9.6% \(the highest percentage when compared to acute, ambulance, community, and specialist sectors\)](#)<sup>13</sup>.

Existing plans to expand the workforce have not been met, or are behind target, and reforms to the Mental Health Act risk stretching resources even further. In the plan to deliver the Five Year Forward View for Mental Health<sup>14</sup>, the Government set a target to employ 570 more consultant psychiatrists by April 2021. The strategy has now concluded, and two out of three of all the posts are unfilled (185 posts out of a target 570). As the workforce plans for the NHS Long Term Plan are meant to be on top of this, we are already 400 consultant psychiatrists behind the target for 2020/21.

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<sup>9</sup> NHS Digital (2019) Detentions under the Mental Health Act. Available at: <https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/2.1> (Access 19 April 2021)

<sup>10</sup> Ibid.

<sup>11</sup> Ibid.

<sup>12</sup> Royal College of Psychiatrists (2019) Census. Available at: [https://www.rcpsych.ac.uk/docs/default-source/improving-care/workforce/census-final-update060720-1.pdf?sfvrsn=bffa4b43\\_8](https://www.rcpsych.ac.uk/docs/default-source/improving-care/workforce/census-final-update060720-1.pdf?sfvrsn=bffa4b43_8) (accessed 19 April 2021).

<sup>13</sup> NHS England (2019) Quarterly performance of the NHS provider sector: quarter 4 2018/19. Available at: <https://www.england.nhs.uk/financial-accounting-and-reporting/quarterly-performance-of-the-nhs-provider-sector-quarter-4-2018-19/> (accessed 19 April 2021)

<sup>14</sup> Health Education England (2017) Stepping forward to 202021 - The mental health workforce plan for England. Available at: <https://www.hee.nhs.uk/sites/default/files/documents/Stepping%20forward%20to%20202021%20-%20The%20mental%20health%20workforce%20plan%20for%20england.pdf> (accessed 19 April 2021)



There are both direct and indirect impacts of the reforms on the workforce, which need to be properly considered. The proposals should, therefore, be supported by a workforce plan to understand the extra demand and training that is required to deliver the proposals. We are commissioning a piece of research to model the impact of these reforms on the psychiatric workforce. We would be happy to share our findings with DHSC in due course to support workforce planning.

It should also be noted that the reforms are coming at the same time as growing demand for mental health services due to COVID-19. Our survey of over 1,300 mental health doctors from across the UK in May 2020 revealed that 43% of psychiatrists have seen an increase in their urgent and emergency caseload.<sup>15</sup> According to Public Health England, psychological distress, anxiety and depressive symptoms have been reported to increase during periods of national lockdown.<sup>16</sup> The Centre for Mental Health has predicted that **up to 10 million people (almost 20% of the population)** in England will need either new or additional mental health support as a direct consequence of the crisis.<sup>17</sup> This extra demand must be factored into workforce planning if the reforms are to be realised.

## Sufficiency Duty

The potential impact of this White Paper and the necessary investment needed to successfully implement its proposals are detailed throughout our submission.

The legislative proposals are, in many cases, unlikely to be able to remove many of the problems that are caused by inadequate service provision and we stress the need for any changes to be accompanied, or preferably preceded by substantial investment in community mental health and learning disability services as well as the workforce.

To this end, we would welcome any provision in the Act of a sufficiency duty, a concept that can be found in the Children Act with regard to the need to ensure that local authorities have sufficient accommodation for looked after children. This may lend itself well to NHS commissioning bodies.

Section 22G of the 1989 Act requires local authorities to take strategic action in respect of those children they look after and for whom it would be consistent with their welfare for them to be provided with accommodation within their local authority area. In those circumstances, section 22G requires local authorities, so far as is reasonably practicable, to ensure that there is sufficient accommodation for those children that meets their needs and is within their local authority area.

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<sup>15</sup> Royal College of Psychiatrists (2021) Briefing Analysis of second COVID-19 RCPsych member survey – indirect harms. Available at: [https://www.rcpsych.ac.uk/docs/default-source/news-and-features/news/rcpsych-covid-member-survey-2-summary.pdf?sfvrsn=951e1c72\\_2](https://www.rcpsych.ac.uk/docs/default-source/news-and-features/news/rcpsych-covid-member-survey-2-summary.pdf?sfvrsn=951e1c72_2) (Accessed on 19 April 2021)

<sup>16</sup> Public Health England (2021) COVID-19 mental health and wellbeing surveillance report. Available at: <https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-surveillance-report/2-important-findings-so-far> (Accessed 19 April 2021)

<sup>17</sup> Centre for Mental Health (2020) Covid-19 and the nation's mental health: October 2020. Available at: <https://www.centreformentalhealth.org.uk/publications/covid-19-and-nations-mental-health-october-2020> (Access 19 April 2021)

We would welcome any such provision in the Mental Health Act, particularly as may apply to areas where changes are being made where the system is already struggling to accommodate people, including community services for patients with LD and beds for patients being transferred out of prison.

### **Learning Disability – Hospital and Community Services**

There continue to be inappropriate admissions for people with LD to inpatient services when behaviours have escalated to the point of the threshold for admission as a result of inappropriate community support (i.e. inappropriate environment, lack of specialist knowledge or training, or a placement not able to meet the needs of an individual).

In effect, the risk to self or others has escalated to an unsafe level and the burden of responsibility is transferred from local authorities to CCGs to admit patients due to unmanaged risks. There brings a danger of inappropriate and traumatic admissions with little therapeutic benefit. ..

So much of this rests on the availability of robust community services -the lack of which results in hospital detentions and delayed discharges. These proposals and resourcing of services need to be optimised as it is not clear how this will be achieved.

Before removing aspects of hospital care, there would need to be assurances that alternatives care options are fit for purpose.

Hospital resources must match the level of community resources required with the increased statutory systems outlined in the proposed changes to the Act. There will be other community service changes required: robust crisis service teams and full MDT community teams, particularly with specialist behavioural psychology for people with autism.

### **Addiction Services**

Another group that has always been excluded from mental health legislation is those with substance use disorders. Funding for NHS addictions services have been consistently cut and a whole range of appropriate treatments are largely denied to most people with substance use disorders as a result. Further, it seems that for many, failure to recognise the full complexity of these disorders has led to ever more stigmatisation of those who struggle with them.

### **Prisons**

Despite the proposed changes to legislation to reduce delays, these are most often due to:

- a lack of available bed in a secure service
- difficulty in accessing a specialist secure bed and geographical variation in supply e.g. brain injury; LD; ASC beds – with no single point of access
- delays in access to assessments due to high volume caseloads/ understaffing
- not all prisons/ courts have mental health teams with access to a responsible clinician who can complete reports/ transfer requests.

Therefore, to achieve the 14 x 2 day limit, additional resources are required as well as changes to access assessments for specialist secure beds in particular.

### **RCPsych Member Survey**

We undertook a survey of members on their thoughts on changes to the MHA. One area in which there was clear agreement was the need for substantial investment to implement the proposed changes.

*When asked 'which of the following statements most accurately reflects the situation in your area when considering the proposed changes to the powers of and referrals to mental health tribunals?'*

- 71.05% of respondents said to successfully implement the proposed changes to mental health tribunals, substantial investment would be required to ensure a sufficient workforce is in place.
- 25.85% of respondents said to successfully implement the proposed changes to mental health tribunals, moderate investment would be required to ensure a sufficient workforce is in place.
- 3.1% of respondents said to successfully implement the proposed changes to mental health tribunals, no investment would be required to ensure a sufficient workforce is in place.

When asked, 'aside from changes to the law, what other changes would be required to make the proposal on making care and treatment plans statutory successful' (please tick all that apply),

- 86.42% of respondents said increased workforce recruitment
- 83.11% of respondents said increased financial resources for services
- 78.64% of respondents said increased training
- 70.2% of respondents said changes to the culture of working
- 0.83% said no change required.

*The proposed changes to the way learning disability and autism are treated in the Mental Health Act will require changes in services. When asked which of the following statements is most accurate in your area?*

- 66.4% of all participants said substantial investment in community services and an expansion of the workforce is required in advance of the changes coming into place. This compares to 90% of LD specialist respondents.
- 9.34% of all participants said moderate investment in community services and an expansion of the workforce is required in advance of the changes coming into place. This compares to 6.67% of LD specialist respondents.

- 2.56% of all participants said no investment in community services and an expansion of the workforce is required in advance of the changes coming into place. This compares to 3.37% of LD specialist respondents.
- 21.61% of all participants were not sure. This compares to 0% of LD specialist respondents.

## **Appendix**

### **Methodology of this response**

The views represented in this submission are based on consultation across the College, specifically through engagement with faculties and committees as well as a member survey, the results of which we attach with this submission.

The College's Faculty of Intellectual Disability ran its own engagement activities in order to consider and address the issues raised and to respond to the proposals in the White Paper. The Faculty consulted its members through a series of focus groups reaching up to 140 psychiatrists in England and Wales covering the range of clinical services. The findings reflect the real-life experience of psychiatrists working in clinical services supporting people with Learning Disabilities.