MHA white paper- Bindmans response

This response to the Mental Health Act white paper is prepared on behalf of Bindmans LLP, an award winning and highly successful London law firm. Elizabeth Cleaver and Basmah Sahib, the authors of this response, are experienced mental health solicitors and long standing members of the law society's mental health accreditation scheme, with extensive experience of representing detained patients and their families.

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?

Your answer can be up to 500 words.

The codification of the new principles of choice, autonomy, least restriction, therapeutic benefit and 'the person as an individual' are a welcome development. We would ask that they are equally applicable to mentally unwell prisoners receiving treatment in prison healthcare wings, particularly those who are awaiting transfer to psychiatric hospitals for treatment. We would also ask that these principles apply to psychiatric patients who are attending general hospital (or accident and emergency departments) to receive treatment for physical ailments. This is to ensure that vulnerable people with mental health diagnoses who require care and treatment do not experience a lapse in the quality of their care, or their personal dignity, at any stage of their mental health treatment – irrespective of their location or entry into secondary mental health services.

Case example: We are currently acting for a prisoner at HMP Thameside who is awaiting transfer to psychiatric hospital for treatment of his chronic, relapsing mental health condition of paranoid schizophrenia. One of his symptoms is heightened suspicion around food that is served to him. He requires packaged food, otherwise he believes it has been tampered with and will decline to eat it. The prison healthcare wing began ordering Kosher food for our client, as this comes pre-packaged. However, this was recently discontinued, our client was told it was 'too expensive'. Of course we will write to the prison healthcare wing asking them to urgently reinstate the packaged meals for our client, but our arguments would be bolstered if the new principles were codified and explicitly extended to include healthcare wings in prisons.

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*

Please give reasons for your answer (up to 500 words).

We share the government's concerns about increasing numbers of unnecessary psychiatric admissions. In our work, we have seen a number of avoidable admissions.

Case example: We acted for a patient, 'TK', who was discharged from section 3 admission to no section 117 aftercare whatsoever. She was made street homeless, her life was too chaotic for her to remember to take her Olanzapine medication resulting in TK experiencing a relapse in her mental health. We challenged the commissioners for failing to offer supported living (where our client could be supported with prompting and reminders to take her anti-psychotic medication), psychological support with the intention of improving her understanding around the benefits of medication compliance and so on. In response to our pre-action correspondence, TK was placed in non-specialist bed and breakfast accommodation with other vulnerable adults for 3 months awaiting an assessment and allocation of a care coordinator. TK suffered such an acute and extended relapse in her mental state in that time, that she ended up in psychiatric hospital again for over a year – part of which she was detained under section 3. If community services were better funded, and not so stretched, it is our view that TK would have been admitted to a supported living placement much earlier – thereby avoiding a relapse and re-admission to psychiatric hospital.

Therefore, in principle we agree with the new detaining criteria requiring an assessment of whether care and treatment (that is to bring about a therapeutic benefit) cannot be delivered without the patient's detention.

However, we caution that this will not necessarily be enough to prevent unnecessary hospital admissions entirely, where community services remain overstretched and underfunded.

<u>Question 3</u>

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*

Please give reasons for your answer (up to 500 words).

We agree and welcome this addition to the detaining criteria.

We can entirely see the benefit to the BAME community and patients with a diagnosed learning disability or autism of the need to identify a specific risk to enable psychiatric admission.

However, guidance must be issued to clinicians around risk assessments for patients who are expressing suicidality, have a history of self-harm or suicide attempts. or whose carers are reporting strange, avoidant or suicidal behaviour of a prospective patient. As inquest practitioners, we have seen too many cases where patients are declined admission to psychiatric hospital unless they are actively suicidal. This appears to be due to limited NHS resources, rather than a patient's risk level. In one case, **('AA')**, the patient (who had a history of overdoses and self-harming) had withdrawn from her care coordinator and was not complying with her prescribed psychotropic medication. The community mental health team ('CMHT') referred AA to the Local Authority for a Mental Health Act assessment but the Approved Mental Health Practitioner ('AMHP') declined to conduct this – without speaking to AA directly - as AA's partner had reported she was fine. AA's main carer at the time was her mother, the AMPH did not speak with her either. AA committed suicide just a few days later. The Coroner was critical of the failure by the CMHT to improve AA's engagement with services and found they ought to have impressed the urgent need for a risk assessment on the AMHP. We are concerned that the introduction of the need for 'a substantial likelihood of significant harm to the health, safety or welfare of the person' will make it harder for suicidal patients to receive treatment – these are patients who often evade services and hide their intentions even from loved ones in order to complete their plans.

We also cannot see any reason why this higher threshold of risk assessments should not also apply to Part III hospital admissions. We disagree that this would limit the scope for professional discretion or judgment. In our experience, Part III patients are often at the mercy of subjective risk assessments by treating clinicians which are not always substantiated by objective proof.

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 III

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

4) Patients on a conditional discharge

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

Please give reasons for your answer (up to 500 words).

We strongly agree with all 4 of these proposals. It is our view that greater frequency of reviews will result in reduced hospital admissions. We have acted for a number of patients who either lack motivation or mental capacity to initiate Tribunal proceedings themselves. The automatic referral mechanism is a key opportunity for the review of the ongoing detention of such patients.

The absence of any automatic referral for patients subject to a conditional discharge places the onus of review on the shoulders of the patient. There are many reasons why a community patient might be hesitant to submit a Tribunal application, including not wanting to disrupt the relationship with their treating team.

Case example: We recently represented a patient who was subject to a conditional discharge and had applied to the Mental Health Tribunal for a review of the Secretary of State's Section 41 power and the conditions attached to her discharge. Her Responsible Clinician accused her of misusing the Tribunal process. We have submitted a complaint against this conduct, but consider that automatic referrals would particularly support those patients who are hesitant to commence the Tribunal process themselves in case this causes a rift between them and their treating team.

Further case example: we acted for a patient who had been conditionally discharged in the community for a period of ten years with no incidents. He had moved to an independent flat. Due to a change in his medication, his mental state deteriorated and he had to be readmitted to hospital. Our client then had to go through a lengthy process of proving that his risks had reduced, and that he was safe to return to the community. As a section 37/41 patient, his leaves had to be approved by the Ministry of Justice, and he faced a lengthy wait for his unescorted leave. After a year of being detained in hospital, he almost lost his home, as his housing benefit stopped. He was eventually conditionally discharged back to his home and he has remained well.

The patient did not have the motivation to apply for absolute discharge during the ten years that he was in the community. Has he done so, he is likely to have been discharged from s41. In these circumstances, when his mental health dipped he could have been readmitted to hospital for a short period on a civil section, enabling a quicker discharge once stable. His lengthy subsequent admission was in our view due to the nature of detention under s37/41 and the Ministry of Justice involvement.

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*

Please give reasons for your answer (up to 500 words).

We strongly disagree with this proposal. There must be an automatic review of the community patient's re-admission to psychiatric hospital. Even if the patient's Section 3 or Section 37 admission resumes, and they apply to the Tribunal in the usual way, the panel will only consider whether continued admission is justified. Unless an automatic review is triggered by the fact of a CTO revocation, the patient will never have an opportunity to scrutinise the reasons for the CTO revocation. We frequently act for patients who dispute the reason for the CTO revocation; e.g. the community mental health team believes the patient has intentionally skipped medication doses; whereas the patient has attempted to access the Clozapine clinic but – through no fault of their own – has been unable to attend an appointment. It is a matter of great importance to the patient that they have an opportunity to contest the reasoning for revoking their CTO, and have their account recorded. The absence of this automatic review will only result in increased complaints against community-based clinicians from patients who are disappointed about being returned to hospital, disagree with the reasons for the revocation of the CTO and have no other recourse

to challenge the decision. The alternative would be to apply to the High Court for a judicial review of the CTO revocation. This will create undue burden on the Administrative Court; the automatic Tribunal referral on CTO revocation must remain.

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*

Please give reasons for your answer (up to 500 words).

We strongly agree with this proposal. In our experience, greater judicial oversight of directions can only improve patient's outcomes and confidence in the Tribunal process. We agree that a period of 5 weeks is a proportionate length of time for these directions to be put in place. Further, leave can be given to the Responsible Clinician or Care Coordinator to file a Position Statement explaining why a direction can no longer be carried out.

Case example: we represented a teenage patient **('BH')** with challenging behaviours. It was agreed that a bespoke community placement – instead of a restrictive hospital environment, where BH was routinely treated in seclusion – was best suited to her. The Tribunal panel was able to progress BH towards discharge from hospital by making helpful directions addressed to the commissioners of the community placement to progress matters for BH. It will benefit patients if this becomes a routine element of the Tribunal panel's role.

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*

Please give reasons for your answer (up to 500 words).

We disagree with this proposal. We acknowledge the government's intention to increase access to the Mental Health Tribunal, but the hospital managers' review is available to a patient at any time and remains an important route to discharge. We disagree that there is a lack of formality during hospital managers hearings **('HMH')**. In our experience, the HMH chair takes evidence in the same way as a Tribunal chair and considers the detaining criteria. The solution to this concern, in our view, is not restrict access to HMH but rather to offer more training and guidance to managers when conducting these hearings.

Question 8

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

Your answer can be up to 500 words.

This list is comprehensive. We only suggest that all of the languages the patient can speak are listed, in order of fluency, along with the relevant dialect to ensure correct interpreters are being used to communicate with the patient particularly where it is suspected that they may have lost mental capacity.

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*

Please give reasons for your answer (up to 500 words).

We partly agree with this suggestion. This is because some of the categories listed in the advance choice document (e.g. religious or cultural requirements; communication preferences etc.) are relevant irrespective of the patient's mental capacity.

It may be prudent to list some matters which are obviously only relevant once a patient has lost mental capacity (e.g. ‘care of children’) under a separate heading within the document.

Question 10

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

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

Your answer can be up to 500 words.

This list is comprehensive. Again, we only suggest that all of the languages the patient can speak are listed, in order of fluency, along with the relevant dialect to ensure correct interpreters are consistently being used to communicate with the patient. The contact details for a particularly effective interpreter could also be included.

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*

Please give reasons for your answer (up to 500 words).

We agree with this proposal. In our view, this will place greater emphasis on the need to engage the patient and obtain their trust, agreement, cooperation and compliance with a treatment plan – which is ultimately a key aspect of the overall therapeutic relationship.

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*

Please give reasons for your answer (up to 500 words).

We strongly agree and welcome this additional power being granted to the Mental Health Tribunal. We consider the proposed safeguards (namely, that the patient must have a valid advance choice document) to be adequate.

We consider that the opportunity for a Tribunal doctor to meet with the patient and discuss their concerns should also be made available, similar to the option of requesting preliminary hearing examinations ahead of Tribunal hearings, and that the feedback from the Tribunal doctor could also assist the judge.

Question 13

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

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

Please give reasons for your answer (up to 500 words).

We strongly agree with the proposed additional powers of the Nominated Person.

May we suggest that, for young or unwell children and vulnerable young adults with learning difficulties / autism who are unable to select a Nominated Person, AMHPs should be given clear guidance / a recommendation that their parent or primary carer ought to be appointed as the Nominated Person.

We frequently act for patients who have had a falling out with relatives, whose living parents are unwell due to their own mental or physical health difficulties and are instead cared for by a friend or other, distant relative. The function of the Nominated Person has an obvious advantage in these cases.

We would only caution that there ought to be a responsibility – either on the detaining hospital, or the local authority – to ensure that the patient's Nominated Person has been informed of their role and consents to it.

In our experience, hospitals routinely decline to give any information at all to the Nearest Relative; going forward guidance must be issued to detaining authorities

explaining that certain basic information (such as section papers) must be provided to the Nominated Person to enable them to carry out their statutory functions. This is already required by case law, but must be codified.

In *R (on the application of S) –v- Plymouth City Council and C* [2002] EWCA Civ 388, the Court of Appeal was asked to consider how the interest of preserving a guardianship patient's confidentiality of personal information could be reconciled with his mother's interests as his Nearest Relative in having access to information about him to exercise the statutory functions under the Mental Health Act. The Court held that both in common law and under the Human Rights Act a balance must be struck between the public and private interests in maintaining the confidentiality of information about the patient and the public and private interests in permitting – or indeed requiring - its disclosure for certain purposes. According to Lady Hale, where there is no suggestion of any risk to the patient's health and welfare arising from such a disclosure then the mother and her advisors should have access to information which will enable her to exercise her statutory powers. This limits the context and the content of disclosure of a patient's information in a way which strikes a proper balance between the competing interests described. This means that in most cases the Nearest Relative should be able to access at least basic statutory documentation (such as section papers) – but in our experience, detaining hospitals routinely decline to offer information to the Nearest Relative (including alerting them to the fact that their relative has been detained under the MHA 1983) based on the patient's wishes alone.

We consider that – in order for the Nominated Person's role to be effective – there must be clarification about the circumstances in which the NP can access a non-consenting patient's records for the purpose of exercising their statutory functions.

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*

Please give reasons for your answer (up to 500 words).

Yes we agree, and – for the purpose of avoiding undue distress to the families of young children detained under the MHA 1983 – we invite the government to publish guidance to AMHPs around assessing Gillick competence and circumstances in which to release information to a patient's parents.

Question 15

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

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

Please give reasons for your answer (up to 500 words).

We strongly agree with this proposal and invite the government to commit funding to IMHA services. In our experience, like community-based mental health services, IMHAs are often over-stretched across innumerable service users and underfunded resulting in unequal access to this crucial service – particularly if the powers of the IMHA are to be expanded.

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*

Please give reasons for your answer (up to 500 words).

We agree that enhanced standards and accreditation (as well as specific training for patients with learning difficulties and autism diagnoses) could improve the advocacy service and indeed make the role easier for IMHAs – they will feel supported through improved training, which can offer an opportunity to meet with other IMHAs and learn through shared experiences. However, we strongly disagree with the proposal to introduce regulation to this role. The practical reality of regular audits could drown already stretched IMHA services in paperwork, making the entire service totally unworkable from a practical perspective.

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?

Your answer can be up to 500 words.

Questions around the boundaries between the Mental Health Act and the Mental Capacity Act have been the subject of debate between lawyers for many years. The Mental Capacity Act is often seen as a less restrictive framework, when in fact the Mental Health Act currently provides additional safeguards for patients, including access to prompt and quick access to reviews of their detention before the Mental Health Tribunal and reviews of treatment by a second opinion doctor. In our view, those who are on a mental health ward and receiving treatment for mental disorder should remain subject to the Mental Health Act, in order to ensure that they benefit from all of these safeguards.

The white paper proposes that patients with a learning disability and autism would no longer fall within the scope of the Mental Health Act. There is some concern that these patients will simply be placed on mental health wards under the Mental Capacity Act, which means that they will have less protection. The removal of patients with autism and learning disability from the scope of the Mental Health Act is a very positive step forward, but must result in concrete change on the ground for this client group. This will not be achieved if this group of patients are still detained in hospital, just under a different legal framework.

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

If you agree, please provide reasons for your answer (up to 500 words).

Are there any safeguards that should be put in place to ensure that an individual's advance consent to admission is appropriately followed?

Your answer can be up to 500 words.

We agree that patients should have the option of implementing an advance decision in relation to informal admission to a mental health unit, and that this should be set out in both the Mental Health Act and the Code of Practice. It is important to ensure, however, that any patient admitted on an informal basis, whether they have implemented an advance decision or not, has given free and capacitous consent to their admission. When well, a patient could decide to implement an advance decision, only to change their mind when their mental state deteriorates and admission to hospital is required. In these circumstances, the safeguards of the Mental Health Act should be implemented, if detention in hospital is necessary and the Mental Health Act criteria are met.

We also agree that any safeguards to ensure that an advance decision is followed should be implemented. The advance decision should be clearly exhibited at the top of an individual's medical file and social care records, and with the patient's consent, they should also be disclosed to family members and advocates.

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*

Please give reasons for your answer (up to 500 words).

In our experience, there can be significant confusion in acute hospital settings in relation to the use of the Mental Capacity Act and its scope. In the confusion of an A&E department, clinicians may not feel equipped to assess a person's capacity in order to make a decision as to whether or not to prevent them from leaving A&E under Section 4B of the Mental Capacity Act. In our view Section 5 of the Mental Health Act is more established and better understood, and would provide a clearer framework for clinicians in these circumstances. We agree with the proposal that this should only be used by senior clinicians.

Section 5 MHA should only however be used to ensure that a patient is held pending an MHA assessment. I recently had a case where a patient was placed under s 5(2) in A&E because she was refusing treatment for her physical health. In those circumstances the MCA was a much more appropriate framework.

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*

Please give reasons for your answer (up to 500 words).

Answer 20

We agree that there should be a 28 day time limit for transferring prisoners in a mental health crisis from prison or immigration removal centres to hospital. This will ensure that those in a mental health crisis within these settings are able to access treatment sooner. We do not consider that there are any additional safeguards that need to be in place before the statutory time limit is implemented, however there is a need for additional resources and bed availability in secure hospitals to receive these patients, as bed availability is the usual obstacle faced by clinicians seeking to transfer a patient from prison to hospital.

Question 21

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/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/ IRC transfer process*
- *an alternative approach (please specify)*

Please give reasons for your answer (up to 500 words).

In our view, the role of the existing mental health professionals should be extended to enable them to also manage prison and immigration removal centre transfers. AMHPs are experienced professionals with detailed knowledge of the Mental Health Act criteria, and would be best placed to undertake this role. We would not support the creation of a new role in this regard. Additional resources will however need to be made available to AMHP Services, which are already stretched, to ensure that they have the resources to undertake this additional role and recruit further AMHPs if needed.

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?

Your answer can be up to 500 words.

We do not have any comments on this issue.

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*

Please give reasons for your answer (up to 500 words).

If you agree, please give reasons for your answer (up to 500 words).

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*

We agree that it should be possible to discharge capacitous restricted patients into the community with conditions that amount to a deprivation of liberty, but only where the patient is in full agreement with the conditions of their discharge.

In our view difficulties may arise where a patient with capacity is discharged subject to conditions that they have not 'signed up to'. The patient may then fail to comply, and would be recalled to hospital. It would also not be appropriate to conditionally discharge a patient to a placement that they do not like, and where they will continue to be effectively detained, but without the same safeguards as those they have access to in hospital under the MHA.

We strongly agree that this group of patients should be subject to annual Mental Health Tribunal review.

Question 24

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

Your answer can be up to 500 words.

In addition to the regular reviews by the Mental Health Tribunal we would propose that there should be a statutory obligation on the Ministry of Justice or the Mental Health Tribunal to review whether any conditions amounting to a deprivation of liberty are in the patient's best interests, and amount to the least restrictive option.

We have some concerns in relation to the decision not to include part 3 patients in the reforms to the Mental Health Act criteria. Many patients subject to Part 3 are detained for excessively prolonged periods of time due to their difficulty in demonstrating that they no longer pose a risk. Patients will remain detained in hospital, for a prolonged period after the completion of their mental health treatment, because they find it difficult to access or engage in the psychological programmes, or the graded leaves, that the Ministry of Justice and the Mental Health Tribunal expect them to complete. It would be a missed opportunity not to include these patients within the scope of the reforms.

We welcome the decision to provide statutory powers to the Mental Health Tribunal to recommend transfer or leave of absence.

Question 25

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

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

Please give reasons for your answer (up to 500 words).

We strongly agree with the proposed reform to the Mental Health Act in the way that it applies to people with a learning disability and autism. Those with autism and learning disabilities are poorly served by the legal framework as it stands. People with autism often find the ward environment extremely challenging, leading to incidents of challenging behaviour, which would not normally occur in the community, that are then used for justification for continuing detention, on the basis that the patient poses a risk to themselves or others.

People with LD and autism are often detained purely because of the lack of appropriate services in the community, not because hospital treatment is necessary.

The risk is that people with learning disabilities and autism will remain detained under the Mental Capacity Act, with less safeguards in place. Any decision to reform the use of the Mental Health Act for this group of patients requires additional resources to be put in place in order to enable these patients to be appropriately supported in the community.

Currently patients' discharges are often delayed by the lack of adequate after care services. There is no financial incentive for local authorities and CCG currently to fund and develop aftercare services immediately upon a patient's admission to hospital. Whilst the patient remains detained in hospital, it is the Trust/NHS England who are responsible for the cost of the patient's stay in hospital. We would propose that CCGs and local authorities should become responsible for meeting the cost of the patient's admission to a mental health unit, in order to create that financial incentive for after care services to be implemented as soon as possible.

Question 26

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

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

Please give reasons for your answer (up to 500 words).

We do not agree that these proposed reforms provide adequate safeguards for those with learning disability and autism when they have a co-occurring mental health condition. The reason for this is that many people with autism are 'over-diagnosed'. This is due to a lack of understanding within acute mental health settings of the challenging behaviour that some patients with learning disabilities and autism display.

For example, I had a patient with moderate learning disability and autism who for many years was also diagnosed with bipolar affective disorder. He was detained under the Mental Health Act for a period of six years in total. When adequately assessed by an autism expert, his behaviours were attributed to his autism spectrum disorder. The bipolar affective disorder was therefore discredited. As a result of the incorrect diagnosis, my client was prescribed mood stabiliser medication which he did not require for many years. Under the current proposed reforms, there may be an incentive to diagnose people with autism and learning disabilities with a co-occurring mental health condition, in order to justify detention in hospital. This must be avoided in light of the fact that people with autism are already over diagnosed.

I also acted for a client for many years who had a diagnosis of borderline personality disorder and learning disability. He spent a total of 23 years in detention, with transfers between different levels of security and different private and NHS units throughout the country. Two years before he was discharged from hospital, my client was finally

assessed for autism and found to meet the diagnostic criteria. His challenging behaviours, displayed over many years, could all be explained by his autism traits, and the borderline personality disorder diagnosis was discredited. As a result of securing the correct diagnosis, my client was finally able to progress towards discharge into the community, supported by a clinical team with specialist in autism spectrum disorder.

Question 27

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 and autistic people?

- *Yes*
- *No*
- *Not sure*

Please give reasons for your answer (up to 500 words).

One downside/concern in relation to the way these reforms are proposed to apply to people with learning disabilities and autism is that they may simply be detained in hospital under the Mental Capacity Act instead, which carries less safeguards and rights of appeal. Changing the legal framework of a person's detention should also be reflected in the practical situation on the ground. People with learning disabilities and autism should be supported in the community, close to their families. Hospitals such as Wholton Hall for example, should not be permitted to simply re-register as care home settings in order to continue to detain people with learning disabilities and autism, but under a different framework.

The mental health system in this country has been privatised over the years. Numerous private hospital providers have taken over provision of specialist care for those with mental health conditions. These include organisations such as The Priory Group, Cygnet Healthcare, St Andrew's, etc. These organisations provide care to those detained under the Mental Health Act at significant cost to the tax payer. There is no financial incentive for these providers to move patients on, or support their discharge back into the community, since they continue to receive NHS funds while patients are occupying their beds. Whilst there are some excellent services within this section, there have also been significant concerns in relation to the quality of care provided by some of these organisations, for example Cygnet Healthcare was the owner of Wholton Hall. Resources need to be made available to the NHS for specialist hospital care to be provided within the NHS, rather than outsourced to these private organisations.

Question 28

We think that the proposal to change the way that the Mental Health Act applies to people with a learning disability and 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*

Please give reasons for your answer (up to 500 words).

We disagree with the proposal not to change the way that the Mental Health Act applies to people with a learning disability and autistic people who are involved in the criminal justice system. This is because part 3 patients are required to demonstrate, over a prolonged period of time, that they have engaged in the necessary psychology and rehabilitation, to be able to progress towards discharge. It is my experience, through many years of acting for patients under part 3, that those with learning disabilities and autism who are subject to part 3 sections, are those that find it the most difficult to demonstrate that they no longer pose a risk to the public. This is because psychology programmes are often not suited to these patients, or they struggle with the ward environment and boundaries, which are not suited to people with autism. It is my experience that people with learning disabilities who are subject to these sections can remain stuck in hospital for many years longer than those with mental health diagnoses.

An additional practical difficulty is that learning disability units are currently being closed down under the NHS England Transforming Care Scheme. This is an initiative which aims at ensuring that people with learning disability and autism receive care in the community, not in hospitals. There will therefore be very few specialist learning disability in patient services that can provide specialist care to part 3 patients. Consequently, these patients may be required to travel long distances to receive treatment, or they may be detained in settings that are not suited to their needs.

In our view it is a mistake not to extend these reforms to people with learning disabilities and autism.

An alternative would be to extend the number of sentencing options available to people with learning disabilities and autism, including community orders.

<u>Question 29</u>

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 and to autistic people?

Your answer can be up to 500 words.

Please see above.

Question 30

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*

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

We strongly agree that the recommendations from Care & Treatment and Care, Education & Treatment Reviews should be formally incorporated into a care and treatment plan for patients, and that a responsible clinician should be required to explain if recommendations are not taken forward.

Currently the effectiveness of CTRs and CETRs is limited. Panels will make recommendations, however the treating teams do not have to follow these, and community teams do not have to respond or ensure that community services are provided as recommended.

I am currently representing a young man with autism and learning disability who is detained within the section 136 suite on an acute mental health ward. He is clearly not detained within the right environment, despite having a community team and a home that he could return to. He has had three CTRs since his admission, all of which have made recommendations for his community team to be able to complete their training with him, and for adaptations to be made to the ward environment so that this is better suited to his needs as an autistic person. None of the recommendations have been complied with, and there is currently no mechanism for ensuring that the recommendations are implemented. In addition, the clinical team's engagement with

the CTR process has been poor, as there are no consequences for them if recommendations are not followed. CTR panel members are experts, and their recommendations should have more teeth.

Question 31

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 and autistic people. Do you agree or disagree with this?

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

Please give reasons for your answer (up to 500 words).

We strongly agree with this proposal. As suggested above, we would also add that local commissioners should have to pay for in-patient treatment, which would create a financial incentive for community services to be made available for people with learning disabilities and autism.

Question 32

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 and 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*

Please give reasons for your answer (up to 500 words).

We agree with this proposal, which should assist in ensuring better crisis management for individuals who are at risk of admission. In my experience, people with learning disabilities and autism are admitted to hospital in crisis, due to insufficient resources

being made available in the community. Better crisis management would lead to less admissions to hospital within this group.

Question 33

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 and autistic people?

Your answer can be up to 500 words.

We have no comments on this issue.

Question 34

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

Your answer can be up to 500 words.

We have no comments on this issue.

Question 35

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 (up to 500 words).

We note that the reforms will lead to an increase in Mental Health Tribunal referrals. Each of the patients referred to the tribunal will require legal representation. Due to extremely low levels of remuneration under Legal Aid for this type of work, the number of solicitors practicing in this field is decreasing. Steps will need to be taken in order to ensure that sufficient lawyers are practicing in this area of work in order for patients to receive legal representation.

Alternatively, please email your response to mhaconsultation2021@dhsc.gov.uk and include what question you are responding to and your organisation (if appropriate).