

# The independent review of the Mental Health Act

Interim report

1st May 2018

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# 1. Foreword

Everybody has “mental health”, but far too many of us have mental health problems. For many years this has existed in a twilight zone, both in society in general and the NHS in particular. There is now a welcome desire and indeed some success in bringing it into the light. The effect of light, though, is to illuminate not only what is important but also to draw attention to those areas which, whilst no longer in the dark, remain very much in the shadows.

In recent years, there has been necessary attention given to issues such as anxiety, depression, relationship problems, how people react to adversity and so on. We have seen unprecedented investment in talking therapies for those with common mental health problems, and an upsurge of general interest in mental health, aided by campaigns such as “Time to Change” or “Heads Together”.

However, mental health problems lie on a spectrum, and most of this new interest is at one end of the spectrum, with far less attention given to those at the other end of the spectrum, those with the most severe forms of mental illness. Yet those with the most severe forms of mental illness have the greatest needs, and continue to be the most neglected and discriminated against. Furthermore, they are also the group who are the most likely to be subject to the influence and powers of the Mental Health Act (MHA).

The MHA confers powers on the state that do not exist across the rest of health care. These powers are usually exercised when people are at their most vulnerable. Where people are anxious, quite reasonably, that their rights and personal dignity may suffer through the use of those powers, the state is under a heavy obligation both to ensure that they are no greater than necessary and to oversee and regulate their use.

This independent review was set up to look not just at our mental health laws, but also how they interact with services, good practice and the wider care system. This has raised many difficult issues as the substance of our interim report makes clear. Whilst we have come to a few provisional decisions, most of the matters raised here are still very much open for discussion.

Our remit is broad. We have been specifically tasked with looking at the rise in the use of the MHA over the last 10 years, but also the significant over-representation within that cohort of BAME communities and, within that, a significant over-representation of people of African-Caribbean and African descent.

Whilst this over representation is neither new nor unrecognised, it is fair to say that there remains no single explanation for this, although there is now a reasonable consensus that social and societal reasons are paramount<sup>1</sup>. If the rise in compulsion in the last decade is clear and unwelcome, equally clear but welcome is the increased emphasis being given to the rights of patients as service users<sup>2</sup>, as opposed to the previous predominant focus on issues of risk and safety, which of course remain important.

Some of these rights are directly enforceable under the Human Rights Act 1998. Those that arise under other conventions remain aspirational: they are acknowledged but they are not legally enforceable. This is a recipe for confusion and requires further thought.

However, we should not concentrate solely on rights, but also the broader issues of human dignity. Even at this early stage of our work, we have heard time and time again from service users who have been previously detained<sup>3</sup> under the MHA, who, looking back, can see why this was necessary at the time. But far too often they go on to raise serious issues about the manner in which this was done, and then the circumstances of their subsequent stay in hospital.

All too frequently we have heard about practices and procedures which fell short of respecting their dignity, even when this was perceived as being in their best interests at the time.

It is also clear that our inpatient wards cannot always be seen as the most therapeutic of environments, at exactly the moment in time when that is what is most needed. This is usually a practice issue in that it concerns less what powers exist but how they are exercised.

These issues lie at the heart of a service that truly seeks to address the needs of service users. Possible solutions to these issues and problems, some if not most of which may not be best addressed by legislation, will occupy much of our remaining time. We will consider whether we can enshrine guiding principles in statute and we would like to achieve that. However, these principles must be sufficiently clear and precise to be legally enforceable; aspirational principles have their place in a Code of Practice but may not be workable in a statutory context. This requires further detailed work.

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1 Morgan C, Hutchinson G. The social determinants of psychosis in migrant and ethnic minority populations: a public health tragedy. *Psychological Medicine* 2010;40: 705-709

2 Language note: throughout this report we will use the term 'service user' to refer to patients detained under the MHA. We note that there is not a clear consensus on either term but some people do prefer patient.

3 Language note: throughout this report we have used the term 'detention' instead of 'sectioned'. We note that there is not a clear consensus on either term but some do prefer "sectioned".

The MHA cannot be viewed in isolation from the practical and legislative context in which it operates. An aspiration of the review was and remains to reduce the number of individuals subject to compulsory detention. In other words, the aspiration is to increase informal admissions and/or alternatives to admission, rather than compulsory admissions, in keeping with the original intentions of modern mental health legislation, first laid out in the 1959 MHA.

This has been made more complex since the passing of the Mental Capacity Act (MCA) in 2005 and the more recent judgment of the Supreme Court concerning the meaning of deprivation of liberty. This has brought into stark relief the problem of those who have agreed to hospital admission, or at least show no signs of objecting to it, but who may still be de facto deprived of their liberty in various ways – for example residing in a locked ward. Should they actually attempt to leave, even if unintentionally, they would be stopped from doing so, even for as simple a reason as to prevent them wandering into a busy road, as might happen to a person with severe dementia. In this case, the current laws make it clear they are being deprived of their liberty, even if they show no signs of objection, which means they must now become subject to the MCA machinery.

This is no minor or trivial issue. Indeed, if present trends continue, there can be no doubt that the overall level of compulsion being exercised by the State is certain to increase further. Likewise, the cost of these additional safeguards is likely to consume a substantial part of the existing Local Authority and NHS budgets currently allocated to this area.

It will be necessary very carefully to consider the interface between the MHA and the MCA more widely. Should MCA concepts of Powers of Attorney, Advance Decisions to Refuse Treatment, and court-appointed Deputies have a role in care governed by the MHA? Should we join up advocacy services provided by both pieces of legislation, possibly with other health advocates, to produce a unified and accredited service? Surely it should be possible to standardise the legal oversight between the Court of Protection and the Mental Health Review Tribunals so that at least issues of detention can be dealt with by the same tribunal. It may also be necessary to consider if and how their jurisdictions could be widened.

There are other areas in which we are also clear, even at this early stage, that change is necessary: Community Treatment Orders and the nearest relative provision being examples.

We are also clear that the whole area of the overlap between the criminal justice system and mental health needs an overhaul. Processes are too slow and complex and secure services are too often subject to long delays in both admitting and discharging people.

There is also a great reluctance, both moral and practical, to detaining those with mental health problems in environments such as police cells, when no crime has been committed. There have been welcome developments in this field even as recently as last year, but we will be considering if these go far enough. It is heartening to note that those involved, whether they be medical teams, social services, police, the Home Office or Ministry of Justice, all want to travel in the same direction.

Issues of treatment, especially where there is no consent, are also difficult, but we know that we need to find solutions to ensure that we have sufficient safeguards to ensure compatibility with the European Convention on Human Rights, which is and will remain part of UK Law. We are also looking in depth at the UN Convention on the rights of persons with disabilities. In addition, we are studying other legislative structures for mental health that currently exist, for example, in Scotland and soon in Northern Ireland. It would be folly not to learn from their experiences, whether positive or negative.

There are inevitably many specific areas that require attention, such as aftercare and the use of second opinion doctors (both with potentially significant financial implications). There are particular issues affecting young people aged 16 – 17 as well as those of any age with learning disabilities or autism. We need also to revisit the concept of 'risk' to ensure that there is real substance to it.

So our intention is to look at a range of options for reforming the MHA, from large-scale changes to more specific amendments, combined with system and practice changes where these are also needed. We are mindful of the current short term issues that limit ambitious legislative proposals, but that will not prevent us looking further into the future.

Overall, we remain committed to the goal we set out when we began – namely to make the MHA work better for everyone. We know that much of what is required to achieve these goals, of a mental health service that provides dignified and therapeutic care for those with the most severe of mental illnesses, is not going to be achieved by legislative means alone. We know that issues such as resources and staffing are fundamental to these objectives.

We also know that issues such as poverty, discrimination, isolation and racism all play a part in the causes of mental illness, even if those lie beyond our power or remit.

We know that many of the issues regarding the care of both young people and adults are not specific to the MHA, and have already been considered as part of the Five Year Forward View and Future in Mind projects. There is little point in simply repeating the conclusions of either of those reports, all of which we are in agreement with, and all of



which need to be implemented. But we also know that legislation can play its part in moving closer to these goals, and that it can sometimes help to lead social change.

This introduction is just that, an introduction. Those of you looking for early evidence of our thinking in other areas should read on. And those of you who feel that we have already gone too far - or not far enough - should be at least partially reassured that this is very much an interim report. The majority of our work remains to be done.

But even at this stage we want to express our thanks to the extraordinary numbers of people who have already contributed their experiences, thoughts and knowledge to the work so far. We will be calling on the time and knowledge of many of you again before the task is complete.

In conclusion, we would like to recommend our interim report for study by any to whom the mental health of our society matters. We look forward to having our thinking further refreshed and challenged by your continuing contributions.

Professor Sir Simon Wessely, Chair of the independent review

Steven Gilbert, Vice-Chair

Sir Mark Hedley, Vice-Chair

Rabbi Baroness Julia Neuberger, Vice-Chair

## 2. Executive summary

This independent review of the Mental Health Act 1983 (MHA) was commissioned by the government in October 2017. Our terms of reference ask us to make recommendations for improvement in relation to rising detention rates, racial disparities in detention, and concerns that the act is out of step with a modern mental health system. We were asked to look at both legislation and practice, with recommendations extending to England in relation to matters that are devolved in Wales (including health), and England and Wales in relation to non-devolved matters (including justice).

This interim report summarises our work so far, and the priority issues that have emerged for further examination. We are just halfway through our work so these are early findings. We remain keen to engage with as many people as possible, and to examine all relevant evidence as we develop recommendations for our final report later this year.

Our ultimate goals have been set by our terms of reference to make recommendations for improvement in relation to rising detention rates, racial disparities in detention, and concerns that the act is out of step with a modern mental health system.

During the course of the review we will explore many opportunities for reform in detail. We have developed a set of more detailed goals to help guide our work. Our hope is that when faced with different options, these goals, we have developed will guide our work and remind us what we are ultimately aiming to achieve.

We have developed these goals by drawing on feedback from our service user and carers' group, and our advisory panel.

Put simply, our overarching aim is to make the MHA work better for everyone. With that in mind, we will seek to achieve the following:

- Service users and carers being treated with dignity and respect
- Greater autonomy for people subject to mental health legislation
- Greater access to services for those that need them
- Making the least restrictive option appropriate to a person's circumstances the default option
- Improved service user and carer wellbeing
- Service users and carers supported to be fully involved in treatment as possible
- Reduced disparities between groups with protected characteristics

- Greater focus on rights-based approaches
- Reduced harm and improved safety for all
- Professionals better able to deliver their expertise

Our first priority has been to hear directly from people affected by the MHA.

We have now:

- Received over 2,000 survey responses from service users and carers
- Supported over 30 focus groups of service users and carers
- Listened to 320 people at our workshops
- Attended over 70 meetings and events

We are grateful for people's willingness to share their experiences and make suggestions for change.

In addition to this engagement, we have commissioned academic literature reviews and new data analysis on a number of themes. Much of this work is ongoing, but early findings in a number of areas have informed this report.

We have identified a large number of opportunities for improving the MHA and associated practice. This report summarises the messages we have heard on each issue, and sets out the areas we propose to consider further. A table summarising the areas for further consideration is annexed.

Our survey explicitly asked whether service users agree or disagree that being detained has been the best approach for their mental health needs. Many service users had a positive or largely positive view that it was the right course of action, with some service users, on reflection, commenting that being detained saved their life and prevented suicide. However this view was not universal and an almost equal number did not believe detention had been the right approach for them. Even at this early stage of our work we have heard time and time again service users raise serious issues about the manner in which they were previously detained under the MHA and the circumstances of their stay in hospital. This includes many people who accept that detention was necessary. All too frequently we have heard about practices and procedures which fell short of respecting their dignity.

It is clear that the MHA needs to change. The need to tackle this lack of dignity and respect drives many of the specific reform areas that we are considering.

We are clear that improvements cannot be achieved by legislation alone. Whilst legislative change is critical, any changes to the MHA must be underpinned by improvements to mental health services.

The causes of rising detention rates are complex, and we will continue to examine them closely. Our examination of local and national data has found the rise reflects more individuals being detained overall, rather than some people being detained more often. In seeking to address this, we will pay particular attention to whole-system approaches that seek to reduce the need for detention, including health and care services alongside other partners like the police. Multi-agency approaches are also vital in supporting discharge, and we will consider how to improve care planning and the system of aftercare for service users who have been detained.

We have already found that the MHA could be improved to do more to enable a person's wishes, including via the provision for advance planning, and the reform of rules for involving families and carers, alongside the reform of Community Treatment Orders.

Advocacy is seen as an impactful safeguard by many service users, but provision is currently patchy, standards are variable, and the role of different types of advocates is confusing. We will also be examining opportunities for reform of other safeguards, notably the role of tribunals and managers' hearings, and requirements for consent.

Experiences of people from black African and Caribbean heritage are particularly poor and they are detained more than any other group. Too often this can result in police becoming involved at times of crisis. The causes of this disparity are complex, but we have heard that services can improve, in particular by taking proper account of people's cultural circumstances and needs.

We are clear that the MHA must work well for all people affected. We have heard concerns about inappropriate use of the MHA in relation to people with a learning disability or autism, potentially linked to lack of appropriate alternative provision in the community. In relation to children and young people, we will examine issues of parental involvement and decision-making in particular.

We have heard that the interaction between the MHA and the criminal justice system can be improved. Service users are left too long in prisons when they should be in hospital. Decision making about restricted patients is often lengthy. We are pleased to see broad support amongst statutory services to make improvements here.

We want to rescue the notion of the 'informal patient' who is not subject to legislation. As well as tackling rising detention rates, we intend to consider what should, and should not, amount to a 'deprivation of liberty' at the interface of the MHA and the Mental Capacity

Act. This builds on the government's acknowledgement of the urgent need to reform Deprivation of Liberty Safeguards (DoLS).

We hope to produce recommendations in these areas, and possibly others, which will make the MHA work better for everyone. We are keen for people to get involved in the next stage of our review. We will provide more updates via our [webpage](#), and via [email](#) to those who have contacted us.

### 3. Introduction to the review

This independent review of the Mental Health Act 1983 (MHA) was commissioned in October 2017 by the UK government. Our terms of reference ask us to make recommendations for improvement in relation to rising detention rates, racial disparities in detention, and concerns that the act is out of step with a modern mental health system. We were asked to look at both legislation and practice.

The purpose of the review is to understand the causes of the issues outlined above as well as any additional issues with the functioning of the MHA. We will then make recommendations to help the government create a forward-looking plan of changes to both legislation and associated practice.

This interim report summarises our work so far, and the issues that have emerged as priorities for further examination. We are at an early stage of our work so our findings are provisional. We remain keen to engage with as many people as possible, and to examine all relevant evidence as we develop recommendations for our final report later this year.

The recommendations made by the review will extend to England in relation to matters that are devolved in Wales (including health), and England and Wales in relation to non-devolved matters (including justice).

## 4. The review's goals

Our ultimate goals have been set by our terms of reference; to make recommendations for improvement in relation to rising detention rates, racial disparities in detention and concerns that the act is out of step with a modern mental health system. During the course of the review we will explore opportunities for reform in detail. We have developed a set of goals to help guide our work. Our hope is that when faced with different options, these goals will guide our work and remind us what we are ultimately aiming to achieve.

We have developed these goals drawing on feedback from our service user and carers' group, and our advisory panel.

Put simply, our overarching aims to make the MHA work better for everyone. With that in mind, we will seek to achieve the following:

- Service users and carers being treated with dignity and respect
- Greater autonomy for people subject to mental health legislation
- Greater access to services for those that need them
- Making the least restrictive option appropriate to a person's circumstances the default option
- Improved service user and carer wellbeing
- Service users and carers supported to be fully involved in treatment as possible
- Reduced disparities between groups with protected characteristics
- Greater focus on a rights-based approaches
- Reduced harm and improved safety for all
- Professionals better able to deliver their expertise

## 5. How the review is carrying out its work

We have examined a range of evidence sources to develop our initial priorities. This section summarises our work to date. We will continue to develop our understanding of the available evidence as the review progresses.

Our first priority has been to hear directly from people affected by the MHA.

### **Hearing from people affected by the MHA**

In the last few months, we have focused on consulting with people who have direct experience of the MHA, the people who support them and the organisations who represent their views nationally. We have also engaged with people and organisations that use the MHA in the course of their work, within the health and social care, legal, voluntary and community sectors.

We have undertaken a dedicated service user and carer survey to learn about their experiences of and attitudes to detention under the MHA.

We invited organisations to express an interest in running service user and carer focus groups. These focus groups facilitated detailed discussions and there were several that considered issues affecting specific groups, such as people from BAME communities, people with learning disabilities, people with autism, children and young people and carers. Focus groups also included service users within different levels of secure hospital units.

There have been workshops hosted in Cardiff, Newcastle and London which included a broad mix of service user, carer and professional attendees.

In February 2018, we hosted a roundtable at 10 Downing Street to discuss priorities for African and Caribbean communities. Attendees included a wide range of stakeholders with expertise on issues of race and mental health, and topics of discussion included substance misuse, secure care, race equality and unconscious bias.

Throughout the process, we have fulfilled requests to speak at meetings and events about the review. We are actively seeking further opportunities to meet with organisations and groups to listen to their issues and discuss potential solutions.



Overall, we have now:

- Received over 2,000 survey responses
- Listened to 320 people at our workshops
- Supported over 30 focus groups
- Attended over 70 meetings and events

We are grateful for people's willingness to share their experiences and make suggestions for change.

### **Other evidence**

We have commissioned academic literature reviews to gather the latest evidence on the following themes:

- Legal frameworks and rates of detentions in Europe
- Clinical and social predictors of compulsory admission
- Service users and carers' experience of compulsory admission
- Interventions to reduce compulsory admissions
- Use of the nearest relative provisions in compulsory detention and ongoing care of people
- Advance planning
- Clinical effectiveness of Community Treatment Orders

We have commissioned public bodies and two mental health trusts to conduct detailed data analysis to explore the issues of variation in detention rates, re-detention, comparisons of informal and formal admission and success rate of tribunal appeals. We are also considering the impact of characteristics including ethnicity, age, and gender and protected characteristics.

In addition, over 150 sector organisations and bodies responded to our formal call for evidence. These responses have been detailed and reflected a range of topics and issues.

## 6. Governance of the review

From the outset, we have aimed to conduct a review that is shaped by those who have personal and professional experiences of the MHA and its associated practices. To achieve this, we have established a range of different groups to support, challenge and shape our recommendations.

All of these groups have established terms of reference that include a list of members, roles and organisations they represent. This information is available on our webpage<sup>4</sup>.

### **Working group**

The Chair and Vice-Chairs are supported by experts, including service users and carers, to develop their recommendations and reports. These members are providing further advice, working to ensure that the review's outputs are founded on the available evidence, and reflect the contributions of an appropriate range of stakeholders.

### **Service user and carer focus group**

A group of service users and carers are helping to shape recommendations across the breadth of the review, and advising on how we engage with service users and carers more broadly.

### **The African and Caribbean group**

This group is making recommendations designed to ensure that people of African and Caribbean descent with mental health challenges receive the treatment and support they need, when and where they need it, are treated with dignity, and that their liberty and autonomy are respected as far as possible. This will include focused engagement with people within these communities.

### **Evidence and analysis group**

This group is advising on evidence relating to the MHA, with a particular focus on data and academic evidence. They are advising how we can utilise this evidence to best effect, highlight evidential gaps and suggest ways to address these.

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<sup>4</sup> <https://www.gov.uk/government/groups/independent-review-of-the-mental-health-act>

## **Advisory panel**

We have over 40 stakeholders as part of our advisory panel which serves as a forum for gathering evidence and insight throughout the course of the review. Overall, they will help to shape the review's products and recommendations.

## **Topic groups**

We are in the process of establishing a number of topic groups to examine particular issues in more detail.

# 7. Key topics

Drawing on the views we have heard and the evidence considered to date, the following issues have emerged for particular consideration by the review. We remain open to new evidence, and emphasise the provisional nature of our thinking at this early stage in the review.

## Before detention

### 7.1 Addressing rising numbers of detentions under the Mental Health Act

Our literature review has found that detentions rates in England<sup>5</sup> are about average for Europe, but they appear to be rising faster in England than elsewhere. Overall admission rates have not risen alongside compulsory admission rates. Despite a reduction in beds, the total number of admissions has remained largely stable in recent years<sup>6</sup>. As a result, there is a growing proportion of people in inpatient wards who are under the compulsory provisions of the Mental Health Act (MHA) (either at the point of admission or during their stay).

We have been seeking evidence about why the number of detentions under the MHA has grown steadily, for each of the last ten years. Our initial analysis of national and local data suggests the rising number of detentions reflects more individuals being detained, rather than some people being detained more often.

There is not a single cause for the rise in rates in detention but rather a number of possible explanations in both the literature and evidence we have received so far. The Care Quality Commission (CQC) recently conducted a number of visits to consider why detention rates have been rising, which concluded that legislative change alone may not have a major or immediate effect on this issue<sup>7</sup>.

We have been told people are not receiving the care they need in the community, and which might have prevented them from reaching crisis. We have also been told that a reduction in acute bed numbers has made the use of the MHA more important to get someone a bed when needed, although compelling evidence on this is unclear. More broadly, there are wider concerns about increased risk aversion amongst professional

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<sup>5</sup> As discussed at section 7.18, the remit of the review is limited in relation to Wales, hence the reference to detentions in England alone.

<sup>6</sup> NHS Digital (30 November 2017) Mental Health Bulletin: 2016-17 Annual Report [online]

<sup>7</sup> CQC (January 2018) Mental Health Act The rise in the use of the MHA to detain people in England

following high profile judgments and inquiries<sup>8</sup>, the increased scope of compulsion following specific amendments in MHA 2007 and confusion about the overlap of MHA and the Mental Capacity Act (MCA) and which framework is the most appropriate to apply.

We also know that rates of compulsory admission are higher among some black, Asian and minority ethnic (BAME) groups<sup>9</sup>. Understanding this and trying to find ways of reducing compulsory admissions of black African and Caribbean people in particular is one of the main challenges for the review. The higher detention rates seen in BAME groups are considered in section 6.12.

There have been suggestions from our literature review that joint crisis plans can reduce compulsory admissions and high fidelity home treatment and crisis resolution teams can reduce overall admissions. It has also been suggested that a range of street triage models may reduce use of section 136 of the MHA. In addition, increased investment and resourcing of community mental health services and good inter-agency working may also help reduce compulsory admissions<sup>10</sup>.

#### **We will consider further:**

- **What interventions could reduce use of the MHA and compulsory admissions, such as but not limited to, joint crisis plans, models of street triage and high fidelity home treatment and crisis resolution teams**
- **Opportunities to take a ‘whole system’ view of this issue. We will seek examples of where local areas have sought to reduce compulsory admissions in order to learn from what has worked and what has not**
- **Both legislative and non-legislative ways of encouraging or mandating closer interagency working between services**
- **Opportunities to improve risk and safety assessment**

## **7.2 Decisions to detain under the Mental Health Act, and renewals**

The decision to detain, either at the stage of initial admission or at the point of renewal, is primarily based on risk. A theme identified by many stakeholders has been the emphasis on risk and the differing risk thresholds that are applied when making decisions about using the MHA or continuing to detain a service user when a renewal is due.

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8 Example: the judgment of the Supreme Court in the case of Melanie Rabone [2012] UKSC 2.

9 NHS Digital (10 October 2017) Mental Health Act Statistics, Annual Figures: 2016-17 [online]

10 Weich S, McBride O, Twigg L. (2017) "Variation in compulsory psychiatric inpatient admission in England: a cross-classified, multilevel analysis" *Lancet Psychiatry* 4(8) 619-626

The majority of service users who responded to our 2018 survey and the Mental Health Alliance survey, published in 2017, expressed the view that detention under the MHA is sometimes necessary. In some circumstances, we have been told that action taken under the MHA saved people's lives, despite them arguing at the time against detention. Similar views have also been recently expressed by service users in Scotland<sup>11</sup>. However, there are strong views that the process was distressing, and for some service users, resulted in negative perceptions of detention. What we can do to change this will be considered in more detail in section 6.6 about the dignity and respect of service users.

We have also been told that there are concerns about the decision-making process at the point of detention and the ability for service users to challenge these decisions. There is a perception of imbalance between a services user's independence, the least restrictive option of care and efficient use of available resources. This can extend to renewal procedures which, we think, should support the coordinated delivery of care and enable service users to understand the rationale for ongoing detention when necessary.

In addition, it has been suggested that section 2 and 3 of the MHA could be combined into a single section which allows a shorter maximum period of detention for all service users.

From the evidence we have heard, a single section might allow more appropriate and robust safeguards to be in place for renewal. It would reduce the complexity needed at the point of initial detention for many service users when deciding between assessment, treatment and appropriate treatment available.

**We will consider further:**

- **Whether current risk thresholds under the MHA are the right ones, and if not, what they should be**
- **How the MHA can support positive risk taking and standardised/operationalised risk assessment when making decisions for detention and renewal**
- **Whether the appropriate treatment requirement is adequate to ensure a person really is receiving clinically effective help while being detained**
- **Whether sections 2 and 3 of the MHA should be combined or reconfigured, with an initial shorter period for assessment and treatment**

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<sup>11</sup> See the consultation undertaken by the Mental Welfare Commission in Scotland in 2016/2017 in relation to the views of service users and carers' groups on Capacity, Detention, Supported Decision Making and Mental Ill Health [online]: See also chapter 2 of the May 2017 report from the MWC and Centre for Mental Health & Capacity Law.

### **7.3 Interfaces with the Mental Capacity Act**

The Mental Capacity Act 2005 (MCA) stands alongside, but in principle is entirely distinct from, the MHA. The MCA relates to a person's ability (capacity) to function and to make a particular decision. This is different to the status of someone diagnosed with a mental disorder as defined in the MHA and who is subject to its powers. The MCA covers all decision-making, whereas the MHA 1983 is largely limited to decisions about care in hospital and medical treatment for mental disorder.

A key interface of the MHA and MCA concerns the authorisation of the deprivation of a person's liberty in hospital which may arise from some aspect of their care and treatment for mental disorder. In particular, there are concerns about those who are confined for purposes of assessing or treating mental disorder but do not have capacity to consent to that confinement, and who are therefore considered to be deprived of their liberty.

A person can only be deprived of their liberty by a lawful process. A person can consent to a deprivation of liberty, but if a person is unable to consent or is refusing, then either the MHA, or the MCA Deprivation of Liberty Safeguards (DoLS) must be used.

There is significant criticism about the effective use of DoLS. This has become more challenging following the decision in the *Cheshire West*<sup>12</sup> case by the Supreme Court because it widened the definition of a deprivation of liberty. Following this decision, we have been told about the significant practical difficulties and confusion caused when making decisions about whether or not the MHA or the MCA should be applied, particularly in the context of general hospitals.

We are also concerned to understand how the issues with DoLS are contributing to the increased use of the MHA. In addition, we are concerned that this could negatively impact those who voluntarily admit themselves into hospital but will subsequently be subject to the legal status of being deprived of their liberty.

We recognise that the government asked the Law Commission to undertake a fundamental review of the DoLS legislation. We agree and support the urgent reform of DoLS to make sure service users receive the most appropriate care for their needs. In addition, there needs to be an appropriate calibration between resources spent on delivery of care and those spent on safeguards surrounding the delivery of that care.

The government has recently responded and broadly accepted their conclusions. The government has also indicated that it awaits our recommendations on the interface issues,

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<sup>12</sup> P v Cheshire West and Chester Council & Anor [2014] UKSC 19

including whether the proposed Liberty Protection Safeguards (LPS – the Law Commission’s proposed replacement for DoLS) should authorise a deprivation of liberty for somebody at risk of harming other people as well as themselves.

Some people have expressed concerns that having separate mental health and capacity legislation is discriminatory. A broader question for consideration is whether the MCA and MHA should be ‘fused’ to remove this discrimination. We have been told that in the absence of fusion law, there could be fusion of appeals and safeguarding systems to prevent confusion and the duplication of cases being considered by the Court of Protection and Mental Health Tribunals.

It is likely that, if only for practical reasons, we will be unlikely to be recommending ‘fusion’ between the MCA and MHA in the short term, but will be considering this as a longer-term option.

**We will consider further:**

- **Whether and how legislation could enable the return of informality to the delivery of mental health care and treatment in hospital**
- **Whether there are recommendations that can be made prior to the end of the review to solve the urgent problems identified to date, in particular the dramatically rising numbers subject to DoLS<sup>13</sup>/MHA<sup>14</sup>**
- **The specific legislative issues identified as falling for consideration by the review in the government’s response to the Law Commission proposals**
- **The definition of deprivation of liberty given by the Supreme Court in Cheshire West, whilst taking account of the parallel inquiry of the Joint Committee on Human Rights into liberty and security, and the government’s response to the Law Commission’s proposals**

## **7.4 Police role**

The police recognise that helping people with mental health issues is a part of their core business. The police are key partners in the community-based model of mental health care. This is particularly true in cases of immediate responses to people in mental health crisis, where the police have specific powers under the MHA to section people for short periods of time under sections 135 and 136. The use of these powers has remained at a high level over the last decade. This underlines the importance of the police role, but also

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13 NHS Digital (1 November 2017) Mental Capacity Act (2005) Deprivation of Liberty Safeguards, (England) 2016/17, Official Statistics [online]

14 NHS Digital (10 October 2017) Mental Health Act Statistics, Annual Figures: 2016-17, Experimental statistics [online]



challenges the NHS to ensure that services are available and ready to take over responsibility at the most appropriate time.

The contribution of police officers to crisis care has been praised by the CQC, but nevertheless should not have to make up for gaps in health care provision. This is especially so because for many people, interactions with the police can be upsetting and stigmatising, and at the very least not therapeutic. This is particularly the case for certain BAME communities, such as African and Caribbean individuals. There has been a significant reduction of the use of police custody for people held under section 136 but not yet enough to end this practice entirely.

Another emerging issue is that people who are arrested under criminal law stay in police cells for too long after an approved mental health professional (AMHP) has decided that they should be admitted to hospital. It should be a matter of principle that those who are unwell should be treated within the NHS rather than a police cell. This principle should extend to the transportation of service users under the MHA which should under most circumstances be conducted by NHS ambulance services.

We believe that the care of people in cells is as much an issue for health and social care as it is for police. We will consider whether NHS England should take over the commissioning of police custody health care services, or otherwise create a plan so that people in police custody get better care, and faster transfers out to NHS and social care services.

Finally, but crucially, equality issues are of the utmost importance when it comes to all police work, and we will consider how new approaches and innovations from forces have helped to address the experience of people from BAME communities who come to the attention of the police when needing mental health support.

**We will consider further:**

- **How recent legislative changes to sections 135 and 136 are changing service approaches and whether it is right to bring an end to having a police cell designated as a place of safety. If so, what safeguards and resources are needed to do this safely?**
- **Why people who are arrested under the criminal law are staying in police cells for too long after an approved mental health professional has decided that the person needs to be admitted to hospital, and what can be done to address this**
- **Why police vehicles rather than ambulances are still transporting the majority of people under these sections, and what can be done to address this**

- **The practicalities and benefits of NHS England taking over the commissioning of health services in police custody, as has been recommended in both the Angiolini<sup>15</sup> and Bradley<sup>16</sup> reports**
- **Equality issues, particularly police interactions with people from BAME communities under the MHA**

## **During detention**

### **7.5 Dignity and respect of the service user**

Whilst a person is detained under the MHA, the importance of how that person is treated is paramount. There are many ward staff and professionals that are dedicated to creating and maintaining therapeutic environments as well as providing the most appropriate care.

We have heard examples of excellent care, where service users reported that they were treated with dignity and respect throughout their detention. However, just one third of those that expressed a strong view to our survey felt they were treated with dignity and respect and two thirds did not.

It is concerning that people often do not feel safe, treated with dignity or that their human rights are respected whilst detained. The inherent power imbalance means detained patients are vulnerable to potential coercive mistreatment, abuse and deprivation of human rights, leading to physical and psychological harm.

Throughout all of our engagement with service users and carers, we have been made aware of a wide variety of distressing experiences including but not limited to, experiencing or witnessing physical violence, verbal abuse and threats, bullying and harassment, sexual predation, pain-based restraint, coercive reward and punishment systems for access to open air, leave or family contact.

We have been told that issues can sometimes escalate when trying to discuss or challenge diagnosis or treatment decisions. There are further issues surrounding the circumstances which medication is administered to service users. This will be explored further in section 6.9 which concerns itself with the use of restraint and seclusion.

There are wider concerns about how ward environments can contribute to poor therapeutic relationships which echo themes identified in recent CQC MHA monitoring reports<sup>17</sup>. We have been told how mixed sex wards, understaffing, over-occupancy and pressure on

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15 Rt. Hon. Dame Elish Angiolini DBE QC (October 2017) Report of the Independent Review of Deaths and Serious Incidents in Police Custody [online]

16 Lord Bradley (April 2009) Bradley Report [online]

17 CQC (2018) "The state of care in mental health services 2014-17" [online]

beds, the use of agency staff and a lack of supervision can be challenging for staff and service users where they arise. In addition, there are concerns about the capacity of community and regulatory oversight and investigation to address the many concerns that have been raised.

Such negative experiences are likely to be caused by a complex combination of factors and require action on many fronts. We are aware that some options for reform may extend beyond the MHA and relate to workforce numbers, facilities, staff training and supervision, and culture change within care settings.

**We will consider further:**

- **The issues identified in our ongoing service user engagement including our survey and other sources**
- **Learning from successful initiatives to improve care for the service user**
- **Opportunities to improve systems for identifying and addressing poor or abusive care as well as changing regulatory systems and safeguards**
- **Opportunities to improve redress for service users and carers**
- **The possibility and impact of introducing guiding principles onto the MHA itself, in particular considering the principles currently in the Code of Practice**

## **7.6 Autonomy of the service user**

We have heard from many service users that there are times when it can be beneficial to treat someone against the wishes they express in a moment of crisis. Yet there is a sense that the overall balance of the service user's autonomy is not currently supporting them to express their wishes and have their wishes respected. This is a theme we pick up on in several sections below.

### *Consent to treatment*

In certain circumstances, the MHA allows a person to be given mental health treatment against their will, whether or not they have capacity to consent to that treatment. There are only very limited exceptions. By contrast, an adult with mental capacity can refuse treatment for physical conditions even if that decision would be considered unwise by many.

There are well-argued and coherent positions to support and challenge this distinction. It can be argued that it is discriminatory and should be ended, but also that the two situations are not identical or equivalent. We are concerned with the impact of unintended consequences that may result from fusing the mental health and capacity-based

legislation. For example, there is a risk that a person with a mental disorder could be detained for a prolonged period of time without the possibility of treatment.

We are aware of a different system in Scotland which includes the concept of 'significantly impaired decision making' as one of the grounds for detention under mental health legislation. Whilst this is not rigidly defined, it is distinct from capacity and therefore the threshold of satisfying this concept is lower. It hinges upon being able to understand and retain information.

We are not yet minded to recommend moving immediately to 'fuse' mental health legislation and mental capacity legislation, not least because this would take many years to design. However, this is an option to be considered seriously for future reform. This overlaps with the previous section on the interface between the MHA and the MCA in section 6.3, the discussion of advance care planning below, and consideration of measures to support individuals to take decisions and plan in advance for times when they are too unwell to take them.

**We will consider further:**

- **Whether service users have enough say in MHA decisions, and if not, how this could be increased or other safeguards provided**
- **Whether a person's mental capacity and decision-making ability should play a role in detention and/or treatment under the MHA, and at what points**
- **The potential for unintended consequences from different approaches to reform**

*Advance planning*

There are opportunities outside of the MHA for a person to explain how they wish to be treated in the future, at any point where that person may become too unwell to tell people their preferences. Those can include both advance decisions to refuse specific types of treatment, and statements about what the person would like. Those over 18 can also appoint an attorney to make health and welfare decisions for them.

There is also a cross-over in older people's care, when dementia and physical conditions can run side by side, and advance statements can provide guidance to what treatment would be acceptable.

In the specific context of the MHA, however many service users told us they felt their attempts to set out what they did or did not want did not receive adequate attention. We have already concluded that more needs to be done to ensure that more prominence is

placed on a person's wishes and opinions about future care, including where the person has sought to empower someone else to make decisions on their behalf.

This is a question of outcomes for the service user, as well as legal rights. Our starting point is the principle that there will be better outcomes for the service user if they can have a say in as many aspects of their care and treatment as possible.

We are also speaking with colleagues in Scotland, where the Mental Health (Care and Treatment) (Scotland) Act 2003 put 'advance statements' which include both refusals and statements of wishes, into statute. In Scotland, clinicians are required to have regard to them, and any treatment provided which overrides a valid advance statement must be reported to the Mental Welfare Commission.

Whilst we are minded to make improvements in this area, we will not lose sight of the problems that might arise from making any form of advance planning completely binding. As an example, the risk that service users may not receive appropriate care.

**We will consider further:**

- **How the existing legal framework under Part 4 of the MHA and MHA Code of Practice can be better implemented to strengthen advance planning**
- **Whether additional legislative reforms are needed**

## **7.7 Procedural safeguards**

### *Treatment safeguards*

A person detained under the MHA can be given most forms of medical treatment for mental disorder during the first three months of their detention regardless of whether they consent. Second Opinion Appointed Doctors (SOADs) must authorise continuing treatment where the person either does not consent or does not have the capacity to consent, although urgent treatment can be given in the absence of such authorisation where specific conditions are met. The Tribunal does not have any jurisdiction to hear challenges about treatment, which must be made by way of judicial review.

Several issues have been identified through the evidence from stakeholders and CQC annual reports. This includes the adequacy of safeguards during the first three months against the imposition of treatment, in light of the evolving case-law of the European Court of Human Rights<sup>18</sup>, and how to reduce the distress for patients from receiving compulsory treatment particularly when they have capacity to consent or refuse this treatment. In

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18 X v Finland [2012] ECHR 1371 and LM v Slovenia [2014] ECHR 608

addition, there are concerns around the use of emergency treatment powers<sup>19</sup> and whether a judicial review is an adequate route of challenge to decisions about medication made by clinicians and/or authorisations by SOADs.

These issues are likely to have a greater impact for service users who have capacity at the point that treatment is prescribed and their refusal is overruled, or service users who have prepared advance decisions which can be overridden by the MHA.

**We will consider further:**

- **The appropriate route to securing safeguards for patients in the initial period of detention, whether that be under sections 2 and 3 of the MHA as they stand, or under a reconfigured version of these sections**
- **The appropriate route to securing safeguards for patients thereafter and revising the current urgent or emergency treatment exemptions**
- **Whether service users should be able to appeal to the Tribunal against compulsory treatment decisions. If so, in what circumstances and with what conditions**

## **7.8 Tribunals and hospital managers' hearings**

A service user and nearest relative have two different and independent options to review a decision to detain or continue detention under the MHA. The first option is a hospital managers' hearing, where an independent panel considers the potential for discharge. The second option is to apply to the Tribunal in England or the Mental Health Review Tribunal for Wales.

We have been told by service users that they are not always aware of their rights to a Tribunal and this has previously been noted in CQC reports. It has also been suggested that Tribunal powers could be extended to provide further safeguards about care and treatment decisions. Another important issue for service users is the limited opportunity to apply to a Tribunal.

*“Why are patients only eligible for a tribunal once a year? Why not every six months? If a patient is well then it's a lot of waiting.”*

We have also heard an overarching concern about how satisfactorily and effectively Tribunals and hospital managers are able to carry out their functions. Several issues have been identified from CQC reports, the Administrative Justice and Tribunals Council and from evidence provided by relevant stakeholders. This includes but is not limited to the

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19 CQC (2015) Monitoring the Mental Health Act in 2015/16 [online]

current demand on Tribunal and clinical resources, potential duplication between Tribunal and hospital manager hearings, confusion about which court a person without capacity should apply to and the respective roles of the Tribunal and Secretary of State for Justice in relation to restricted patients.

In addition, there is concern following a recent Court of Appeal decision on MM about how to ensure that service users can be conditionally discharged to the community where this is clinically appropriate<sup>20</sup>.

We are also interested to learn from the Scottish model of Tribunals and in particular, their experience of hearing appeals against the level of security to which patients are subject.

**We will consider further:**

- **How to ensure that the Tribunal provides an effective and proportionate safeguard for patients subject to the MHA**
- **The role that hospital manager hearings should play in the future**
- **How Tribunals sit amongst other safeguards inside and outside the MHA including other parts of the judicial system**
- **Whether the Tribunal should provide the sole channel to challenge being subject to the provisions of the MHA and if so, whether a service user should be allowed to apply more than once in the statutory period if there is a change in circumstance**

## **7.9 Advocacy**

Independent Mental Health Advocates (IMHAs) provide an important safeguard for people covered by the MHA, helping them maintain some level of autonomy and engage with a complex system.

The importance of advocacy and the variability of provision have been strong themes emerging in our engagement with service users and carers. A primary concern is the lack of service user awareness about how to access and qualify for advocacy. There is also confusion about which type of advocacy is suitable and/or whether a person qualifies because there are different types available through community advocacy, IMHA and the Care Act 2014 (Care Act).

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20 Secretary of State for Justice v MM [2017] EWCA Civ 194 (permission to appeal this decision has been granted by the Supreme Court but it is unlikely to have been decided before the Review completes its work).

There are wider concerns about inadequate funding which means people are not receiving a full service, as well as the limited training and professional support available for advocates.

There is also evidence that indicates people from BAME communities and older people have specific and greater problems accessing IMHAs. We have heard that advocacy provision does not address the multiple disadvantages and discriminations faced by BAME communities. Our initial work with BAME groups has suggested culturally appropriate advocacy can be a particularly powerful safeguard for some BAME service users. However, many groups are under-served.

We are currently minded to look towards extending and protecting the role that advocates can play, learning from models available in other territories such as Wales. We will also consider the potential for streamlining different advocacy frameworks to introduce a simpler and more consistent approach.

**We will consider further:**

- **How services can ensure advocacy is available and suitable for all, especially in terms of being culturally appropriate**
- **Whether the right to advocacy should be extended to more people**
- **The legal basis for advocacy and whether the requirements need to be better set out in law or guidance (including how different advocacy services could be streamlined)**
- **The current state of IMHA training and how to increase its quality**
- **How national standards, reporting requirements, monitoring and oversight, or other mechanisms might be used to facilitate better implementation and delivery of advocacy services.**

## **7.10 Family and carer involvement**

### *'Nearest relative' legal role*

The role of the nearest relative, as defined in section 26 of the MHA, is to safeguard people who are detained and to ensure that their family has a statutory role in their care. Our view is that this no longer fit for purpose. In practice, carers, family and friends who are not eligible to be nearest relative can struggle to engage in the care of the person they support.

Throughout the review, service users and carers have repeatedly told us how important it is to be able to choose who is involved in discussions about their care. This view is also widely shared by organisations and professionals. At present, this provision and the statutory order of preference of the nearest relative can result in inappropriate people



automatically being selected to be the nearest relative<sup>21</sup>. AMHPs have highlighted the complexity of identifying the correct nearest relative.

There are also specific issues for service users with non-traditional family structures, families, carers and friends who live a long way from the hospital and those who have suffered physical, sexual and psychological abuse at the hands of family members. In addition, the displacement process for unsuitable nearest relatives takes too long, and can result in extensions of some forms of detention beyond the normal time limits.<sup>22</sup>

This can be even more critical when there is a dispute about the next steps for treatment and we have heard particular concerns from the families of people with a learning disability or autism.

*“The default position seems to be that the carer will be a problem, an ‘amateur’ who will not co-operate and will be angry and critical.”*

Any consideration about a future model will need to take into account how disagreements can be resolved in the service user's best interests without significant delays in treatment.

#### **We will consider further:**

- **Reforming the nearest relative provision to allow individuals to nominate a person of their choice to fulfil this role. This will also consider how this could apply for children and young people**
- **Granting the nominated person a statutory role in treatment decisions and whether this could mirror the principles of the Power of Attorney and Deputyship provisions in the MCA**
- **Appropriate safeguards in relation to the appointment and discharge of nominated persons, including where the relevant person user lacks capacity**
- **Other mechanisms through which the carers, families, and friends of people who are detained can be supported to be involved in care of the person they support**

#### *Confidentiality and access to information*

Other than the statutory elements of information sharing related to the nearest relative function, the MHA does not specifically mention information sharing with family and friends. Normal rules of patient confidentiality apply to people who are detained and this

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<sup>21</sup> The Mental Health Alliance (2017) A Mental Health Act Fit for Tomorrow [online]

<sup>22</sup> Displacement proceedings for nearest relatives can mean the extension of a section 2 beyond the normal 28-day limit.

means that information about their diagnosis and treatment cannot be shared with friends and relatives without the consent of the detained person.

There are also wider concerns about how and to what extent family members and carers can be informed about decisions and the treatment of the person they support.

There is little published evidence, but we have heard there are concerns that carers' views and experiences may not be listened to when the person they support is admitted into hospital, and that carers may not be able to access information about treatment. However, there are also instances where information about people who are detained is inappropriately shared with relatives, against the detained person's wishes.

This suggests that achieving the right balance between protecting confidentiality and the appropriate involvement of family, friends, and carers is difficult.

**We will consider further:**

- **Non-legislative approaches to ensure a better balance between protecting confidentiality and appropriate disclosure**
- **How any replacement of the nearest relative provision can be used to improve appropriate access to and sharing of information**
- **The framework that needs to be in place for the authorisation of sharing information and the resolution of disputes**

## **7.11 Use of restraint and seclusion**

The use of restrictive practices on service users detained under the MHA has been highlighted as a concern over several years. This stems from reports about the very poor experiences of service users, and in some cases, their deaths.

We have regularly heard concerns about the wide variation in the use of restraint between Mental Health Trusts and some evidence indicates that certain groups are more likely to experience restraint, principally people from BAME communities<sup>23</sup>. We have also heard that restraint is used disproportionately on women<sup>24</sup>.

Some initial evidence suggests that creating a positive 'ward culture', de-escalation approaches, post-incident reviews and quality improvement approaches can all reduce the risk of conflict in inpatient settings that may lead to the use of restrictive practices.

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<sup>23</sup> NHS Digital's 2016/17 Mental Health Bulletin shows that for the white ethnic population, 15.8 people per 100,000 were subject to restrictive interventions, compared with 39.5 per 100,000 from the mixed/multiple ethnic population and 52.1 per 100,000 who are Black/African/Caribbean/Black British [online]

<sup>24</sup> Agenda (March 2017) "Agenda briefing on the use of restraint against women and girls" [online]

In 2014, the then Department of Health produced new guidance<sup>25</sup> to reduce restrictive interventions and there was a subsequent drop in restraint in most service areas but a rise in other settings, namely in high secure settings for people with a learning disability, high-dependency rehabilitation wards, medium and high secure mental health wards, and children and young people's non-forensic services<sup>26</sup>.

Further work on reducing the use of restrictive interventions is under way across national organisations as part of a wider mental health patient safety focus. This includes improving the quality and completeness of routinely published data. Moreover, Steve Reed MP's Mental Health Units (Use of Force) Private Member's Bill, is currently going through Parliament and is supported by the government.

**We will consider further:**

- **The practice of restraint and seclusion in relation to a person's detention, and the options available to strength the principle of least restrictive practices**
- **We will monitor closely the ongoing legislative and policy developments in this area, and consider if and where it is appropriate for us to make further recommendations**

## Leaving hospital

### 7.11 Community Treatment Orders

Community Treatment Orders (CTOs) were introduced in the 2007 amendments to the MHA as a form of supervised community treatment for people who have been detained under section 3 and certain other sections of the MHA in order to allow suitable service users to be safely treated in the community rather than in hospital.

About 5,000 people are currently on a CTO at any time<sup>27</sup>, considerably more than the number estimated by the government prior to their introduction<sup>28</sup>. The latest MHA statistics show that 'Black or Black British' people are nine times more likely to be given a CTO than white people.

Our focus groups and workshops heard criticisms of the current CTO model from service users and carers.

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25 Department of Health (2014) "Positive and Proactive Care: reducing the need for restrictive interventions" [online]

26 CQC (2015) Monitoring the Mental Health Act in 2015/16 [online]

27 CQC (2015) Monitoring the Mental Health Act in 2015/16 [online]

28 NHS Digital (10 October 2017) Mental Health Act Statistics, Annual Figures: 2016-17, Experimental statistics [online]

*"If I could change one thing about the Mental Health Act it would be CTOs, as they do not quite give a person an opportunity to recover and get on with their life."*

However, the Mental Health Alliance survey indicated broad support for the principle of some kind of conditions for some people when they are discharged from hospital when all other options have been exhausted. There may also be a small group of people for whom a CTO is the least restrictive option.

There have been limited evidence reviews on the use of CTOs domestically and therefore most reviews have tended to look internationally to gather a larger sample of studies. Unusually for mental health legislation, there have been three randomised controlled trials for the use of CTOs, one of which is from England.

A systematic review of these trials suggested that CTOs have not achieved their primary goal to reduce re-admissions. However, these trials have been criticised, and there have been other assessments, such as before and after studies, some of which, whilst not as methodologically rigorous as randomised controlled trials, have shown more positive results. That said, qualitative evidence suggests that CTOs are very often experienced as coercive and restrictive by people who are subject to them.

We are not persuaded that CTOs should remain in their current form. In reforming or replacing them, we will start by ensuring that there is clarity of purpose, and also that future provisions do not reproduce the current overrepresentation of some BAME groups, particularly men of black African and Caribbean descent.

**We will consider further:**

- **How CTOs are experienced by individuals and their families**
- **Why people from BAME communities, in particular black African and Caribbean men, are much more likely to be given CTOs and with what outcomes**
- **The disparity of views about the effectiveness of CTOs**
- **Whether some groups of people do derive benefits from CTOs, and in what circumstances**
- **The implications of either reforming or replacing CTOs**

## **7.12 Discharge and aftercare**

### *Section 117 aftercare*

Section 117 of the MHA provides a right of aftercare from local authorities and the NHS to people discharged from hospital from MHA and who need support to stay out of hospital. It

is linked to care planning under the Care Programme Approach (CPA) and the Care Act. It plays an important role in supporting service users, enabling their recovery and reducing the risk of relapse.

The entitlement to section 117 aftercare is limited to those who have been detained under specific sections of the MHA.<sup>29</sup> It is not available to people who leave hospital after informal admission or detained under section 2 who may also have a compelling need for aftercare support. We have received many submissions about this issue and so will be considering this in more detail.

In practice, section 117 aftercare is complex to set up and administer, with differing responsibilities and rules on Clinical Commissioning Groups and Local Authorities. There are circumstances where time and money is wasted seeking clarity on which organisations are responsible for which costs. The consequence of this is frustration for service users and professionals, as well as rising costs which do not necessarily lead to greater support for people in the community.

We believe that a general right to aftercare must continue and will explore the interface between section 117 and the Care Act and prevention based services that reduce the likelihood of re-admission. In addition, we will explore if it is possible to better define aftercare in future legislation.

**We will consider further:**

- **The need to clarify what aftercare means within the modern health and social care system, so that it supports independence and recovery**
- **The case for reforming eligibility for aftercare to improve equity of access**
- **Resolving some of the complex arrangements across health and social care, especially regarding funding and ordinary residence**
- **The need to modernise section 117 aftercare in relation to the provisions of the Care Act**

*Care planning and support in the community*

Care plans are the right of every eligible service user under section 117 of the MHA, the CPA or the Care Act and are a requirement of the MHA Code of Practice. They are supposed to consider what support is needed to help a service user to stay well once they have left hospital and are based on an assessment of needs and often includes a risk management plan or crisis plan. The Ministry of Justice or a Tribunal, on appeal, can

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<sup>29</sup> sections 3, 37, 47, 48 and 45a

request a care plan under section 2, section 3 and forensic sections within part 3 of the MHA.

Care plans are important for multi-agency working, reducing detention and providing the support that is needed to assist recovery and reduce future crisis and possible detentions. However, the CQC regularly reports that care plans are of variable quality and are not always shared with service users. We have been told that service users are not being supported to make decisions about what their care plan should look like.

There are also issues about the extent to which organisations and services are communicating and collaborating with each other to prepare and deliver these plans. We know that care plans do not always cover the key health and social care aspects of a person's life. There are also times when service users can be subject to up to three care plans or more to cover all of the areas and legal or guidance issues needed. It has been suggested that this is partly caused by the lack of a cohesive framework which makes it confusing to identify and implement the most suitable plan for service users' needs.

Whilst reform of CPA is being considered by other review processes, it will be important for us to consider whether or not legislation can improve and develop care planning for people detained by the MHA.

**We will consider further:**

- **The opportunity to bring the requirements of the CPA, the Care Act, the Children Act, NHS Continuing Health Care (as well as other legal provisions) and section 117 care planning together in a coordinated way**
- **Opportunities to drive greater collaboration between bodies involved in preparing and delivering care plans, which may include new statutory duties**
- **How to incorporate opportunities identified in our consideration of advance planning (in section 7.6 above) to any proposed reforms**

## **Issues for particular groups**

### **7.13 Black, Asian, and minority ethnicities**

One of the most significant challenges we face is that the use of the MHA varies widely between ethnic groups. People from black Caribbean, black African and mixed black ethnicity have a particularly high risk of being sectioned. Black Caribbean people are also more likely to come into contact with mental health services through the police<sup>30</sup>, to be re-

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30 E.g. Contact through section 136: NHS Digital (10 October 2017) Mental Health Act Statistics, Annual Figures: 2016-17, Experimental statistics [online]

admitted under the MHA, to be given CTOs<sup>31</sup>, to be admitted to secure hospital, and to have poorer outcomes over time. The government's recent Race Disparity Audit has served to highlight this issue<sup>32</sup>.

A succession of studies over the last two decades has sought to explain these differences, particularly for black men. The impact on black women also needs further exploration. They have provided a range of explanations, including differences in diagnosis and severity of illness; experiences of deprivation and discrimination; historical legacies of slavery and migration; differences in social and family support; public and professional perceptions about risk; the reasons for and impact of recreational substance use; and the role of structural racism within health, social care, education, criminal justice and other institutions.

In summary, whilst there is strong evidence that rates of some mental illnesses are increased in some BAME communities in the UK, there is also evidence to suggest that discrimination, poverty, and social exclusion play a significant part in this. However, the extent to which these elements are present in the over-representation of black people in MHA detentions is unclear. It is also apparent that outcomes are typically poorer for some BAME communities, particularly for black African and Caribbean communities<sup>33</sup>.

Previous research gives few clues about how the MHA specifically should change to reduce these inequalities in experience and outcomes. There is also a relative lack of evidence about the experiences of other ethnic groups, such as people from Asian and mixed backgrounds, many of whom are also disproportionately at risk of being detained. Our focus groups with participants from BAME communities overwhelmingly told us they felt there was a lack of cultural awareness in staff and a need for culturally appropriate care. They also expressed concerns about racism, stigma, stereotyping and overmedication.

*"What the psychiatrists may understand as out of order and therefore psychotic exhibitions of mental disorder, to one in his own understanding of the world according to his culture is not madness at all."*

We need to consider how behaviours of staff that section and admit people affect the likelihood of detention. We also need to consider culturally-acceptable alternatives to detention, such as primary care and community-based solutions, as well as the barriers to uptake of earlier interventions. We know that many BAME people fear mental health

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31 NHS Digital (10 October 2017) Mental Health Act Statistics, Annual Figures: 2016-17, Experimental statistics [online]

32 Cabinet Office, Ethnicity Facts and Figures - Health [online]

33 NHS Digital (29 September 2016) Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 [online]

services, based on their own experiences, and therefore we need to work collectively to show that such experiences can be changed for the better, and that confidence can be restored over time.

*“Our experience has been professionals come with stereotypes, usually negative if a black person. Seems to have to make a special effort to treat us like human beings.”*

At an organisational level, our attention has been drawn to emerging successes of the NHS Workforce Race Equality standard in tackling inequalities in the NHS workforce, and we will consider how such approaches could be translated to mental health policies.

We are also aware that, as with the criminal justice system or indeed any area of society in which people from BAME backgrounds experience worse outcomes, many of the issues and possible solutions are not specific to the mental health, or indeed any single sector, and therefore cannot be addressed by actions or strategies within any single sector either.

We will have several groups examining issues relevant to BAME communities. We have already set up an African and Caribbean Group, which is formed of experts from academic, professional and lived experience backgrounds. They will use systematic methods to review the available evidence, identify gaps and consult with service users and carers about how outcomes for people from black African and Caribbean groups might be improved.

**We will consider further:**

- **The experiences of BAME people of being detained and treated under the MHA, with a particular focus on people of black African and Caribbean descent and including interactions with primary care, social care and criminal justice systems**
- **Why some BAME groups have worse outcomes, including but not limited to being more likely to relapse when they left hospital**
- **Whether specific changes to the MHA or the Code of Practice including the ways they are implemented could help to improve disparities in detention rates and experiences of compulsion**
- **Possible extension of the approaches used by NHS Workforce Race Equality Standard to service users and carers not just staff**
- **The impact of any other broader changes recommended by the review on BAME communities**



## 7.14 Children and young people

Specific legal issues arise in relation to the assessment and treatment of children and young people for mental ill health, in particular because they may well be subject to different legal frameworks operating in parallel. Like adults, children and young people also encounter difficulties in accessing appropriate services close to home in a timely manner.

We hosted dedicated focus groups for children, young people and parents which highlighted some key issues that have been supported by submissions from some of our stakeholders.

There are concerns about information sharing and who is involved in decision making. We heard that some young people were told different things about their mental illness and care to that shared with their parents and this had an impact on their recovery when they heard alternative explanations at a later time. In addition, we have been told there may be specific issues for children and young people according to gender, race and ethnicity which need further exploration.

There are legal complexities and ambiguities surrounding admission and consent to treatment, including the role of parental responsibility. Carers expressed the need to be given more information about the process, especially at the point of assessment, which can be very traumatic for young people.

For children and young people, there are other legal frameworks and their interaction with the MHA that need to be considered. This includes the Children Act 1989, the MCA for those over 16, as well as those applying up to age 25 for young people with special educational needs.

More widely, we have been alerted to particular issues for children and young people who are placed in a hospital far away from their families or detained during their time at school, resulting in a delay in their education. This also includes the transition into adult services.

### **We will consider further:**

- **Which barriers to the delivery of care and treatment stem from poor understanding and/or implementation of the existing legal frameworks and associated guidance**
- **How to identify and secure the appropriate place for family members in decisions about admission and treatment**
- **The impact of any other broader changes recommended by the review on children and young people**

## **7.15 Learning disabilities and autism**

The 1983 MHA defined categories of mental disorder, which included learning disabilities and the full range of autistic spectrum conditions. As a result, people with a learning disability and/or autism could be detained under the MHA without having a mental health condition.

In 2007, the law was amended so that for the purpose of certain provisions of the MHA (including compulsory admission for treatment under section 3), a person with a learning disability will only be treated as suffering from a mental disorder if their disability is associated with “abnormally aggressive or seriously irresponsible conduct.”

One of the key issues raised in our engagement to date is whether learning disability and/or autism should be completely removed from the MHA. Linked to this, we heard concerns that people with a learning disability and/or autism are sometimes detained because appropriate community support is unavailable.

We have also been told about concerns such as the levels of understanding and awareness amongst staff and Tribunal judges about learning disability and/or autism; that detentions under the MHA can last for several years with no prospect of discharge; and that hospital does not necessarily provide the right environment and appropriate care for these particular needs.

There are also wider questions about whether or not learning disabilities and autism are conditions that are treatable under the MHA definition of treatability. Families and carers have said they do not always feel involved in decision making and this can be made worse by living far away from where the person they support is detained. This can be distressing for everyone involved and have a long-lasting negative impact.

We have been struck by the significant level of disagreement about the inclusion of learning disability and autism in the MHA and the subsequent role of the interaction with the MHA to provide the most appropriate care for their needs. We note that a lack of consensus was cited when the government felt unable to proceed with relevant recommendations of the 2015 consultation ‘No voice unheard, no right ignored’.

The Transforming Care Programme is still ongoing and we support its implementation with the resource that is required. We are also aware of Scotland’s dedicated review into learning disabilities and autism within the mental health law, which has now completed its scoping phase.

**We will consider further:**

- **How services can support people with a learning disability or autism in ways that avoid the need for detention, including responses to challenging behaviour**
- **The arguments for and against continued inclusion of learning disability and autism in the scope of the MHA**
- **Opportunities to improve awareness among professionals of the needs of people with a learning disability or autism in the context of the MHA**
- **The impact of broader changes recommended by the review on people with a learning disability or autism**

### **7.16 Criminal justice system and Part 3 of the Mental Health Act**

A guiding principle for the review is that patients involved in the criminal justice system should have equivalence in terms of outcomes, rights and safeguards with civil patients, whilst of course being mindful of the particular public interest around risk and safety.

#### *Prisoners, immigration detainees and transfers to/from hospital*

Prisoners or immigration detainees assessed to have a mental health problem requiring detention in hospital for treatment can be transferred from prison, or an immigration removal centre, under the MHA. Each year, around 1,000 mentally ill prisoners and immigration detainees are transferred to hospital in England and Wales<sup>34</sup>.

In 2016/17, only one third of prisoners in England were transferred within the Department of Health and Social Care's recommended 14 day time frame and 7 percent waited more than 140 days<sup>35</sup>. Respondents to our call for evidence asked for a review of the timetable and multiple stages of assessment and approval, and commented that the availability of beds is a major factor to consider in addressing delays. Participants in a focus group at a secure hospital described frustration in the significant delays several individuals faced, spending too long in prison before hospital treatment could commence. We welcome NHS England's forthcoming Ten Point Action Plan to address these challenges.

Concerns have also been raised about how the environment in prisons and immigration detention centres can negatively impact the experience of people with acute mental illness, and the willingness of clinicians to recommend the remission of offenders back to prison.

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<sup>34</sup> Ministry of Justice (2017) Restricted patients: 2016

<sup>35</sup> National Audit Office (2017) Mental health in prisons

For transferred prisoners serving a life or other indeterminate sentence, currently the Mental Health Tribunal in England and Wales and then the Parole Board separately consider decisions on discharge and release. Respondents to our call for evidence were keen to streamline and shorten this process.

Options for reform will consider how to improve processes and address possible accountability gaps.

**We will consider further:**

- **How to streamline and speed up the process of transfer to and from hospital for prisoners and immigration detainees**
- **How to streamline and speed up decisions on release for transferred prisoners serving life or other indeterminate sentences**

*The restricted patients system*

Some offenders detained under the MHA are restricted patients. While doctors remain responsible for their care, decisions on discharge, community leave, and transfers between hospitals can only be made with the consent of the Secretary of State for Justice. There are over 7,000 restricted patients in England and Wales, approximately 65 percent in hospital and 35 percent living in the community<sup>36</sup>.

Respondents to our call for evidence questioned if the balance is right between the need for such a system to protect the public (by managing these patients' contact with the community) and the disruption it can cause to the care of service users who are also offenders.

Powers relating to restricted patients are held formally by the Secretary of State for Justice and decisions are managed by a casework team in the Ministry of Justice. On the other hand the costs of detention are met by the NHS.

Patients, clinicians and professional bodies said that slow decision making can impede patients' recovery and unnecessarily block hospital beds. Some questioned if these powers could be better held independently from government or at least from the Ministry of Justice. Participants in focus groups at several levels of secure units described a feeling of being in limbo and not knowing when they could move on, in relation to transfers between secure units and requests for leave.

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<sup>36</sup> Ministry of Justice (2017) Restricted patients: 2016

We will consider the case to move or change the powers and/or decision making processes held relating to restricted patients.

**We will consider further:**

- **How to speed up decision making for restricted patients**
- **Whether the specific decision-making powers relating to restricted patients set out in the MHA remain necessary and appropriate, and if it is clear enough how decisions should be made**
- **Which individual(s) or organisation(s) should best hold the decision-making powers for restricted patients**

### *Court powers and processes*

The MHA gives courts sentencing options (allowing people to be sent to hospital for treatment rather than prison, or in some cases, for prison sentences to run alongside detention in hospital). It also provides for courts to detain an accused individual for assessment or interim treatment of their mental health during the court process.

A general concern identified through our call for evidence is the inappropriate use of custody for individuals with acute mental illness, and the impact of wider legislation such as the Bail Act 1976 on this. Difficulties were reported in using section 35 powers (remand to hospital for report on accused's mental condition) in terms of timely access to medical expertise and hospital beds.

Commentators noted recent case law and sentencing guides that may increase the use of section 45A (the 'hybrid order' which directs the person to hospital for treatment alongside a term of imprisonment). There is a lack of consensus as to if, or in what circumstances, section 45A is appropriate to use.

**We will consider further:**

- **The potential to reduce inappropriate use of custody for people with acute mental illness**
- **How to make it easier for courts to use section 35 when appropriate**
- **Sentencing options for courts and the circumstances in which they are used**

### **7.17 Compatibility with human rights obligations**

We are required to ensure the MHA is compliant with the European Convention on Human Rights (ECHR) and the evolving case-law of the European Court of Human Rights in relation to the rights of those with mental disorder. Amongst other issues, we will need to examine whether the current system of procedural safeguards for detention and treatment

in the first three months of any detention are adequate in light of recent decisions of the Court<sup>37</sup>.

We will also need to consider with care how to ensure that those who are subject to compulsory detention under the MHA are afforded effective rights to challenge that detention for purposes of the ECHR, even where they lack capacity to make such a challenge.

There are also the implications of the UN Convention on the Rights of Persons with Disabilities (CRPD). The CRPD was ratified by the UK government in 2009, and, whilst not directly incorporated into our domestic law, it is applied by our courts as an aid to interpretation of the ECHR. The Committee on the Rights of Persons with Disabilities, the treaty body for the Convention, has recently recommended that the UK:

*“abolish all forms of substituted decision-making concerning all spheres and areas of life by reviewing and adopting new legislation in accordance with the Convention to initiate new policies in both mental capacity and mental health laws,” and “repeal legislation and practices that authorise non-consensual involuntary, compulsory treatment and detention of persons with disabilities on the basis of actual or perceived impairment.”*<sup>38</sup>

The UK government has not yet submitted its response to the Committee’s Concluding Observations, but it is clear that, taken together with other statements by the Committee,<sup>39</sup> adopting the approach recommended by the Committee would mean the fundamental recasting not only of the MHA but also of the MCA.

Finally, we need to consider the UN Convention on the Rights of the Child for those under 18 (including the special status that the Convention has under the Mental Health (Wales) Measure).

We are not minded to recommend the complete repeal of both the MHA and MCA.

**We will consider further:**

- **Relevant international instruments and statements of international bodies**
- **Relevant recent law reforms in other jurisdictions, including but not limited to Scotland, Northern Ireland and India**

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37 X v Finland [2012] ECHR 1371 and LM v Slovenia [2014] ECHR 608

38 Concluding Observations on the United Kingdom (3 October 2017, CRPD/C/GBR/CO/1), paras 31 and 35.

39 The Committee’s 2014 “General Comment No. 1 on Article 12: Equal recognition before the law.” CRPD/C/GC/1, para 41; and 2015 “Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities.” para 13.

- **The legal, ethical and political issues arising out of the statements of the Committee on the Rights of Persons with Disabilities**

### **7.18 The Mental Health Act in Wales**

The MHA applies to both England and Wales. The recommendations made by the review are to the UK government, and as such will extend to England in relation to matters that are devolved in Wales (including health), and England and Wales in relation to non-devolved matters (including justice).

The English and Welsh health systems differ in a number of ways. People in Wales have rights set out in the Mental Health (Wales) Measure 2010 which ensures that an assessment of mental health needs is available within primary care, and increases the entitlement to an independent mental health advocate to informal inpatients.

Throughout our considerations about the tribunal system and criminal justice system, we recognise that we may need to make specific recommendations to align with differences in the devolved health systems. However, there will be other areas of reform for health that the Welsh institutions may want to consider further within their own framework. We will continue to engage closely with stakeholders in both England and Wales.

#### **We will consider further:**

- **Opportunities to engage key stakeholders and service users in Wales to consider how reform options will impact Welsh legislative frameworks and associated practices**

## 8. Our work over the coming months and how you can get involved

Over the coming months we will consider the issues set out above in more detail, to generate recommendations to achieve our overarching aim – to make the MHA work better for everyone.

We will work closely with many service users, carers, professionals and organisations and welcome people getting in touch to get involved. The evidence, knowledge and experiences we have received or heard so far have been invaluable in terms of shaping our thinking.

There will be a rolling programme of engagement throughout the review. This will include targeted focus groups to address known gaps in evidence, particularly where there is limited academic evidence, for example around what works for black African and Caribbean people. We will also test emerging thinking and recommendations, and are particularly keen to hear the views of service users and carers.

If you would like to get involved, or if you have specific evidence or experiences relevant to any of the issues and topics set out in this report, please get in touch via:

[MHActreview@dh.gsi.gov.uk](mailto:MHActreview@dh.gsi.gov.uk)

We will provide more updates via our [webpage](#),<sup>40</sup> and via [email](#) to those who have contacted us.

The MHA is clearly a complex, and perhaps unique, piece of legislation. The issues set out in this interim report are those which have emerged, through our engagement and work to date, as priority areas that we should be looking at as part of the review.

We of course continue to welcome further evidence, information or experiences beyond these topics, and we will continue to consider all the information we receive as we continue the review.

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<sup>40</sup> <https://www.gov.uk/government/groups/independent-review-of-the-mental-health-act>



## 9. Table of issues for further consideration

<b>Before detention</b>
<b>Addressing rising numbers of detention under the Mental Health Act</b>
<ul style="list-style-type: none"> <li>• What interventions could reduce use of the MHA and compulsory admissions, such as but not limited to, joint crisis plans, models of street triage and high fidelity home treatment and crisis resolution teams</li> <li>• Opportunities to take a ‘whole system’ view of this issue. We will seek examples of where local areas have sought to reduce compulsory admissions in order to learn from what has worked and what has not</li> <li>• Both legislative and non-legislative ways of encouraging or mandating closer interagency working between services</li> <li>• Opportunities to improve risk and safety assessment</li> </ul>
<b>Decisions to detain under the Mental Health Act, and renewals</b>
<ul style="list-style-type: none"> <li>• Whether current risk thresholds under the MHA are the right ones, and if not, what they should be</li> <li>• How the MHA can support positive risk taking and standardised/operationalised risk assessment when making decisions for detention and renewal</li> <li>• Whether the appropriate treatment requirement is adequate to ensure a person really is receiving clinically effective help while being detained</li> <li>• Whether sections 2 and 3 of the MHA should be combined or reconfigured, with an initial shorter period for assessment and treatment</li> </ul>
<b>Interface with the Mental Capacity Act</b>
<ul style="list-style-type: none"> <li>• Whether and how legislation could enable the return of informality to the delivery of mental health care and treatment in hospital</li> <li>• Whether there are recommendations that can be made prior to the end of the review to solve the urgent problems identified to date, in particular the dramatically rising numbers subject to DoLS/the MHA</li> <li>• The specific legislative issues identified as falling for consideration by the review in the government’s response to the</li> </ul>

### **Law Commission proposals**

- **The definition of deprivation of liberty given by the Supreme Court in Cheshire West, whilst taking account of the parallel inquiry of the Joint Committee on Human Rights into liberty and security, and the government's response to the Law Commission's proposals**

### **Police Role**

- **How recent legislative changes to sections 135 and 136 are changing service approaches and whether it is right to bring an end to having a police cell designated as a place of safety. If so, what safeguards and resources are needed to do this safely?**
- **Why people who are arrested under the criminal law are staying in police cells for too long after an approved mental health professional has decided that the person needs to be admitted to hospital, and what can be done to address this**
- **Why police vehicles rather than ambulances are still transporting the majority of people under these sections, and what can be done to address this**
- **The practicalities and benefits of NHS England taking over the commissioning of health services in police custody, as has been recommended in both the Angiolini and Bradley reports**
- **Equality issues, particularly police interactions with people from BAME communities under the MHA**

### **During detention**

#### **Dignity and respect of the service user**

- **The issues identified in our ongoing service user engagement including our survey and other sources**
- **Learning from successful initiatives to improve care for the service user**
- **Opportunities to improve systems for identifying and addressing poor or abusive care as well as changing regulatory systems and safeguards**
- **Opportunities to improve redress for service users and carers**
- **The possibility and impact of introducing guiding principles onto the MHA itself, in particular considering the principles currently in the Code of Practice**

### **Autonomy of the patient**

<b>Consent to treatment and treatment without consent</b>
<ul style="list-style-type: none"> <li>• Whether service users have enough say in MHA decisions, and if not, how this could be increased or other safeguards provided</li> <li>• Whether a person's mental capacity and decision-making ability should play a role in detention and/or treatment under the MHA, and at what points</li> <li>• The potential for unintended consequences from different approaches to reform</li> </ul>
<b>Advance planning</b>
<ul style="list-style-type: none"> <li>• How the existing legal framework under Part 4 of the MHA and MHA Code of Practice can be better implemented to strengthen advance planning</li> <li>• Whether additional legislative reforms are needed</li> </ul>
<b>Procedural safeguards</b>
<b>Treatment safeguards</b>
<ul style="list-style-type: none"> <li>• The appropriate route to securing safeguards for patients in the initial period of detention, whether that be under sections 2 and 3 of the MHA as they stand, or under a reconfigured version of these sections</li> <li>• The appropriate route to securing safeguards for patients thereafter and revising the current urgent or emergency treatment exemptions</li> <li>• Whether service users should be able to appeal to the Tribunal against compulsory treatment decisions. If so, in what circumstances and with what conditions</li> </ul>
<b>Tribunals and managers' hearings</b>
<ul style="list-style-type: none"> <li>• How to ensure that the Tribunal provides an effective and proportionate safeguard for patients subject to the MHA</li> <li>• The role that hospital manager hearings should play in the future</li> <li>• How Tribunals sit amongst other safeguards inside and outside the MHA including other parts of the judicial system</li> <li>• Whether the Tribunal should provide the sole channel to challenge being subject to the provisions of the MHA and if so, a patient should be allowed to apply more than once in the statutory period if there is a change in circumstance</li> </ul>
<b>Advocacy</b>

- How to ensure that the Tribunal provides an effective and proportionate safeguard for patients subject to the MHA
- The role that hospital manager hearings should play in the future
- How Tribunals sit amongst other safeguards inside and outside the MHA including other parts of the judicial system
- Whether the Tribunal should provide the sole channel to challenge being subject to the provisions of the MHA and if so, whether a service user should be allowed to apply more than once in the statutory period if there is a change in circumstance

### **Family and carer involvement**

#### **'Nearest relative' legal role**

- Reforming the nearest relative provision to allow individuals to nominate a person of their choice to fulfil this role. This will also consider how this could apply for children and young people.
- Granting the nominated person a statutory role in treatment decisions and whether this could mirror the principles of the Power of Attorney and Deputyship provisions in the MCA
- Appropriate safeguards in relation to the appointment and discharge of nominated persons, including where the relevant person user lacks capacity
- Other mechanisms through which the carers, families, and friends of people who are detained can be supported to be involved in care of the person they support

### **Confidentiality and access to information**

- Non-legislative approaches to deliver a better balance between protecting confidentiality and appropriate disclosure
- How any replacement of the nearest relative provision can be used to improve appropriate access to and sharing of information
- The framework that needs to be in place for the authorisation of sharing information and the resolution of disputes

### **Use of restraint and seclusion**

- The practice of restraint and seclusion in relation to a person's detention, and the options available to strength the principle of least restrictive practices
- We will monitor closely the ongoing legislative and policy developments in this area, and consider if and where it is appropriate for us to make further recommendations

<b>Leaving Hospital</b>
<b>Community Treatment Orders</b>
<ul style="list-style-type: none"> <li>• How CTOs are experienced by individuals and their families</li> <li>• Why people from BAME communities, in particular black African and Caribbean men, are much more likely to be given CTOs and with what outcomes</li> <li>• The disparity of views about the effectiveness of CTOs</li> <li>• Whether some groups of people do derive benefits from CTOs, and in what circumstances</li> <li>• The implications of either reforming or replacing CTOs</li> </ul>
<b>Discharge and aftercare</b>
<b>Section 117 aftercare</b>
<ul style="list-style-type: none"> <li>• The need to clarify what aftercare means within the modern health and social care system, so that it supports independence and recovery</li> <li>• The case for reforming eligibility for aftercare to improve equity of access</li> <li>• Resolving some of the complex arrangements across health and social care, especially regarding funding and ordinary residence.</li> <li>• The need to modernise section 117 aftercare in relation to the provisions of the Care Act</li> </ul>
<b>Care planning and support in the community</b>
<ul style="list-style-type: none"> <li>• The opportunity to bring the requirements of the CPA, the Care Act, the Children Act, NHS Continuing Health Care (as well as other legal provisions) and section 117 care planning together in a coordinated way</li> <li>• Opportunities to drive greater collaboration between bodies involved in preparing and delivering care plans, which may include new statutory duties</li> <li>• How to incorporate opportunities identified in our consideration of advance planning (in section 7.6 above) to any proposed reforms</li> </ul>
<b>Issues for particular groups</b>
<b>Black, Asian and minority ethnicities</b>

- The experiences of BAME people of being detained and treated under the MHA, with a particular focus on people of black African and Caribbean descent and including interactions with primary care, social care and criminal justice systems
- Why some BAME groups have worse outcomes, including but not limited to being more likely to relapse when they left hospital
- Whether specific changes to the MHA or the Code of Practice including the ways they are implemented could help to improve disparities in detention rates and experiences of compulsion
- Possible extension of the approaches used by NHS Workforce Race Equality Standard to service users and carers not just staff
- The impact of any other broader changes recommended by the review on BAME communities

### **Children and young people**

- Which barriers to the delivery of care and treatment stem from poor understanding and/or implementation of the existing legal frameworks and associated guidance
- How to identify and secure the appropriate place for family members in decisions about admission and treatment
- The impact of any other broader changes recommended by the review on children and young people

### **Learning disabilities and autism**

- How services can support people with a learning disability or autism in ways that avoid the need for detention, including responses to challenging behaviour
- The arguments for and against continued inclusion of learning disability and autism in the scope of the MHA
- Opportunities to improve awareness among professionals of the needs of people with a learning disability or autism in the context of the MHA
- The impact of broader changes recommended by the review on people with a learning disability or autism

### **Criminal Justice System**

#### **Prisoners, immigration detainees and transfers to/from hospital**

- How to streamline and speed up the process of transfer to and from hospital for prisoners and immigration detainees
- How to streamline and speed up decisions on release for

<b>transferred prisoners serving life or other indeterminate sentences</b>
<b>The restricted patients system</b>
<ul style="list-style-type: none"> <li>• <b>How to speed up decision making for restricted patients</b></li> <li>• <b>Whether the specific decision-making powers relating to restricted patients set out in the MHA remain necessary and appropriate, and if it is clear enough how decisions should be made</b></li> <li>• <b>Which individual(s) or organisation(s) should best hold the decision-making powers for restricted patients</b></li> </ul>
<b>Courts powers and processes</b>
<ul style="list-style-type: none"> <li>• <b>The potential to reduce inappropriate use of custody for people with acute mental illness</b></li> <li>• <b>How to make it easier for courts to use section 35 when appropriate</b></li> <li>• <b>Sentencing options for courts and the circumstances in which they are used</b></li> </ul>
<b>Compatibility with human rights obligations</b>
<ul style="list-style-type: none"> <li>• <b>Relevant international instruments and statements of international bodies</b></li> <li>• <b>Relevant recent law reforms in other jurisdictions, including but not limited to Scotland, Northern Ireland and India</b></li> <li>• <b>The legal, ethical and political issues arising out of the statements of the Committee on the Rights of Persons with Disabilities</b></li> </ul>
<b>The Mental Health Act in Wales</b>
<ul style="list-style-type: none"> <li>• <b>Opportunities to engage key stakeholders and service users in Wales to consider how reform options will impact Welsh legislative frameworks and associated practices</b></li> </ul>

# 10. Glossary

Key Terms	Definition
<b>Advocacy</b>	Activity by an individual or a group providing support to express the views and wishes and to stand up for the rights of people with mental health illness
<b>Approved mental health professional</b>	An approved mental health professional is a person qualified and authorised by the local authority to undertake assessments under the mental health act and decide whether detention under the Act is appropriate
<b>Attorney</b>	A person (aged 18 or over) appointed under the Mental Capacity Act who has the legal right to make decisions (eg decisions about treatment) within the scope of their authority on behalf of the person
<b>Capacity</b>	The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack capacity to take a particular decision (e.g. to consent to treatment) because they cannot understand, retain, use or weigh the information relevant to the decision
<b>Care Act 2014</b>	An act designed to improve people's independence and wellbeing. Local Authorities have a duty to assess peoples wellbeing and care needs.
<b>Care Programme Approach</b>	A care planning system used mainly with people in England who receive specialist mental health care services. Involves an assessment, care plan and a care coordinator to oversee it. People who use care should be involved in their care.
<b>Children's Act 1989</b>	An Act relating to children and young people and those with parental responsibility for them
<b>Code of Practice</b>	Shows professionals how to carry out their roles and responsibilities under the Mental Health Act 1983
<b>Coercive Reward</b>	Rewarding a patient to cooperate with mental health or other professionals involved with their care
<b>Compulsory admission or treatment</b>	Admission or treatment for mental disorder given under the Act, which may be against the wishes of the patient
<b>Court of Protection</b>	The specialist court set up under the Mental Capacity Act to deal with issues relating to people who lack capacity



<b>Court Appointed Deputy</b>	A court appointed person who legally takes care of health, wellbeing and finance for someone with health problems. Also referred to as deputyship
<b>Discharge</b>	Unless otherwise stated, a decision that a patient should no longer be subject to detention, Community Treatment Order, guardianship, or conditional discharge
<b>Dignity</b>	The right to be valued and respected and treated ethically
<b>Deprivation of liberty</b>	Depriving a person of their freedom to act in the way they choose, usually in a care home or hospital after completion of a statutory assessment process, which includes an assessment that the detention is in the best interests of the person
<b>Deprivation of Liberty Safeguards</b>	An authorisation under the MCA given by a 'supervisory body' (a local authority or, in certain circumstances, the Welsh Ministers) which authorises a deprivation of liberty in a care home or hospital after completion of the statutory assessment process
<b>European Convention on Human Rights</b>	The European Convention for the Protection of Human Rights and Fundamental Freedoms. The substantive rights it guarantees are largely incorporated into UK law by the Human Rights Act 1998
<b>Human Rights</b>	Substantive rights set out in the European Convention on Human Rights
<b>Independent Mental Health Advocate</b>	An advocate able to offer help to patients who lack capacity under the Mental Capacity Act 2005
<b>Informal admission</b>	Admission of someone who is being admitted for a mental disorder and who is not detained under the Mental Health Act
<b>Joint crisis plan</b>	A plan to support people during future periods of mental health crisis
<b>Mental disorder</b>	An illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia
<b>Mental Capacity Act</b>	The Mental Capacity Act 2005. An Act of Parliament that governs decision-making on behalf of people, aged 16 years and over, who lack capacity, both where they lose capacity at some point in their lives, for example as a result of dementia or brain injury, and where the incapacitating condition has been present since birth

<b>Mental Health Act 2007</b>	Made several key changes to MHA 1983, laying down provision for the compulsory detention and treatment of people with mental health problems
<b>Pain-based restraint</b>	A type of restrictive intervention which refers to any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person when pain is involved
<b>Power of Attorney</b>	An attorney appointed under the Mental Capacity Act to make decisions in relation to the welfare, property or affairs of a person subject to the Act who lacks capacity
<b>Renewals</b>	The process by which the period of detention under a section of the mental health act is renewed
<b>Restraint</b>	A type of restrictive intervention which refers to any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person
<b>Restricted patients</b>	Patients who, following criminal proceedings, are made subject to a restriction order where it appears that it is necessary to protect the public from serious harm
<b>Respect</b>	Due regard for the feelings, wishes, or rights of others
<b>Section 2</b>	Assessment, patients can be kept in hospital for up to 28 days to allow for medical assessment. An approved mental health professional (AMHP) needs to apply to hospital. Patients have the right to appeal to a tribunal within 14 days, to appeal to hospital managers and to see an IMHA
<b>Section 3</b>	Treatment under section 3, patients can be detained in hospital for treatment for up to 6 months. An AMHP needs to apply to the hospital. Doctors may renew for 6 months then 12 months and patients appeals are allowed every 6 months
<b>Section 117</b>	Health, social care and support services in the community following discharge from hospital and to avoid future admission; especially the duty of the responsible health services and local authority to provide after-care under section 117 of the Act, following the discharge of a patient from detention for treatment under the Act.
<b>Section 135</b>	Warrant enabling a police officer to enter premises to either: remove a person to a place of safety to make an application under part 2 or other arrangements for their care or treatment or take (retake) into custody someone liable to be detained under the Act

**Section 136** An emergency power which allows patients to be taken to a place of safety from a public place if a police officer considers that a person is suffering from mental illness in need of immediate care

**Seclusion** Seclusion refers to the supervised containment and isolation of a patient, to contain behaviour that threatens harm to others

**UN Convention on Rights of Persons with Disabilities** Protects the rights and dignity of persons with disabilities

# 11.Key acronyms

<b>Acronym</b>	<b>Meaning</b>
<b>AMHP</b>	Approved Mental Health Professional
<b>BAME</b>	Black, Asian and Minority Ethnic
<b>CCG</b>	Clinical Commissioning Group
<b>CTO</b>	Community Treatment Order
<b>CQC</b>	Care Quality Commission
<b>DoLS</b>	Deprivation of Liberty Safeguards
<b>IMHA</b>	Independent Mental Health Advocate
<b>LPS</b>	Liberty Protection Safeguards
<b>MCA</b>	Mental Capacity Act
<b>MHA</b>	Mental Health Act 1983 unless otherwise specified
<b>SOAD</b>	Second Opinion Associated Doctor