

Independent Review of the Mental Health Act 1983: supporting documents

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Mental Health Act Review African and Caribbean Group - final report to the review chair

1. Terms of reference

1.1 Purpose

The Mental Health Act Review African and Caribbean group (MHARAC) has been established to support the aims of the Independent Review.

MHARAC will make 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.

To achieve this, MHARAC will:

- Give due attention to the implementation and practice of the Mental Health Act as experienced by people of African and Caribbean descent or heritage
- Identify and critically evaluate a range of relevant evidence and data to support thinking and recommendation development.
- Identify and critically appraise aspects of relevant legislation, and consider issues that may particularly impact people of African and Caribbean descent.
- Identify effective practice and propose solutions to identified issues, which will work in the best interests of people of African and Caribbean descent.

In this report we refer to people of Black African and Caribbean origin, descent or heritage. This includes people who self-identify as Black, Black British or Mixed Heritage.¹

¹ 'Black' is capitalised to highlight that 'Blackness' is about more than skin colour, emphasising the racialised position of African descended people in contemporary society

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1.2 Membership and governance

Co-chairs: Jacqui Dyer and Steve Gilbert

Deputy chair: Shubulade Smith

Members: Diane Aitken, Michael Brown, Dawn Edge, Mike Kelleher, Tony Lingiah, Graham Sale, Anthony Salla, Paulene Samuels and Hari Sewell

Additional contributors: Kevin Ariyo, Gbenga Chesterman, Christian Dalton-Locke, Glicinia Danso, Brendan Dunlop, Martin Glynn, Sonia Johnson, Brynmor Lloyd-Evans, Lottie Millett, Edward Neequaye and Isabelle Stanley

2. Introduction

The profound inequalities that exist for people from Black, Asian and Minority Ethnic (BAME) communities in access to treatment, experiences of care and outcomes following mental health service care represent an overwhelming need for policy change to support effective national, regional and local action:

- The consistent over-representation of Black African and Caribbean people in detention is symptomatic of systematic failures to respond to the needs of these communities, and they have not been reduced by recent policy initiatives such as the [Delivering Race Equality programme](#) in 2005 nor by the implementation of the Equality Act 2010.
- People from Black African and Caribbean communities are 40% more likely than white British people to come into contact with mental health services through the criminal justice system, rather than being referred from GPs or talking therapies.
- Black adults are more likely than adults in other ethnic groups to have been detained under a section of the Mental Health Act.
- White British adults are more likely to receive treatment for mental health problems than adults in other ethnic groups (13.3% for white British adults versus 6.3% for Black adults, who have the lowest treatment rate).

In addition, people of Black African and Caribbean heritage:-

- Are disproportionately subjected to use of section 136
- Have longer average lengths of stay in hospital
- Have higher rates of repeat admissions

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- Have higher rates of seclusion
- Are up to eight times more likely to be placed on Community Treatment Orders (CTOs)
- Are less likely to be offered psychological therapies
- Have higher drop-out rates from cognitive behavioural therapy (CBT) for psychosis

People from BAME communities have an especially high risk of being detained, with Black African and Caribbean communities having poorer outcomes over time. The extent to which factors such as discrimination, poverty and social exclusion play a role in the over-representation of BAME people being detained under the UK Mental Health Act is unclear, despite the significant amount of research seeking to explain observed differences. Much research has linked health inequalities to racism as well as other negative socioeconomic factors. Harvard researcher, Professor David Williams described a model that suggests that 'multiple aspects of racism relate to each other and combine, additively and interactively, with other psychosocial risks and resources to affect health' (Williams and Mohammed 2013).

Based on consultation and focus group research with participants from Black African and Caribbean communities, we have concluded that the following factors negatively impact engagement with mental health services and that this affects access and thus will likely affect outcomes for those in need:

- a lack of cultural awareness in staff
- a need for culturally-appropriate care
- structural and institutional factors which engender racism, stigma and stereotyping which increase the risk of over-medication and may play a role in the differential experiences of BAME communities.

We heard from those with lived experience (including carers), professionals and experts in the field of Black mental health. We engaged with Black service user groups as well as individual service users. We did a number of focus groups with Black service users. We gathered a specific working group made up of Black service users and carers as well as professionals. We engaged with Black special advisers with and without lived experience and we ran a community engagement session for members of the Black community in Brixton, South London. In addition, we ran two round tables at 10 Downing Street for Black service users and community leaders. We ran a survey which targeted and received responses from Black people.

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We acted on their suggestions and advice and commissioned research to support our understanding of the issues and to help us develop our recommendations. The scope of this report was not to elucidate the causes of mental ill-health in Black African and Caribbean people. Our aim was to make recommendations about what we thought might help to reduce the disproportionate rates of detention. A theme that came through at the outset and recurred throughout was that of unconscious/implicit bias and institutional racism and the impact that this might have on access, engagement and uptake of services and thus how this might influence outcomes for Black African and Caribbean people with mental health problems.

Information and discussion from the inaugural Roundtable, and from the service user survey, focus groups and consultation were used as a basis for further research (both quantitative and qualitative) and to develop our recommendations. These recommendations were fed back to those with lived experience. The evaluation from this feedback session are available at the end of this report.

2.1 Unconscious bias and institutional racism

Unconscious or implicit bias refers to processes by which we make automatic judgements and assessments of people and situations, influenced by our backgrounds, cultural environment and personal experiences (ECU 2013). This occurs in everyone and is hidden from conscious awareness, so-called 'blindspots' (Banaji and Greenwald 2013). The case has been made consistently that all people carry unconscious biases (Kahneman 2011). Some people hold biases and are discriminatory in their actions, which they deliberately express. This is in contrast to the phenomenon described by Banaji and Greenwald (2013), where it is possible for people to hold biases that they do not consciously endorse. Conscious bias is easier to identify and tackle because it tends to be more direct and explicit; however this may not always be the case. The point to note is that individual bias can be expressed via overtly conscious, subconscious and completely unconscious processes.

The studies of unconscious/implicit bias and prejudice indicate that there is a strong association between different races and the attributes ascribed to them (Plous 1993). Descriptions, language and terminology about racialised minorities are often loaded because of deliberate associations that were created when the concept of race was first developed. It has been argued that there was never a time when the idea of race as a result of scientific classification system was neutral. Race is a political term because it embeds the idea of subordination, whether explicitly or implicitly (Arendt 1944). Thus the term 'racialised minority' is used to emphasise that this group of people are not simply fewer in number.

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Racialised minority identity is disproportionately associated with a cluster of factors which are themselves antecedents of poor mental health, and which are associated with aversive routes of entry into mental health services, poorer pathways and poorer outcomes from treatments offered. A summary of the service and research data on variations can be found in Sewell (2012) and Sewell (2017).

A difference between service data and research is that the latter, when done well, takes account of confounding factors and attempts to zone in on the influence of race. There is, however, a problem in that the process of research and the conclusions drawn appear to be influenced by methodological biases. Barnett et al found that much of the research into ethnicity and involuntary detention was dogged by a paucity of clinical and demographic data; inappropriate ethnic equivalences; simplistic methodologies and the retention of untested methodologies, which served to entrench narratives of racial determinism (Barnett et al, in review).

There is also the issue of internalised (negative) racialised identity. As Banaji and Greenwald (2013) pointed out, racialised minorities also hold strong associations between negative attributes and their own group, as a result of dominant ideas in media, art and society, which is part of their socialisation.

Identifying the influence of unconscious bias on attitudes and behaviour in mental health is difficult because variation in access or outcome for different ethnicities does not automatically equate to race discrimination by the service in question. Merino et al 2018 have provided a comprehensive overview of how implicit bias might impact access to and outcomes in mental health care. They note that the mental health system is more vulnerable to the negative effects of implicit bias "because the diagnosis and treatment of mental health conditions are heavily dependent on provider discretion". They cited research that highlighted unconscious bias on a range of topics such as vigilance as a result of previously being racially profiled. Such racial profiling may be recognised as a cause of an individual's 'vigilance' by one provider but be interpreted as a sign of paranoia related to schizophrenia by another. The paper cites unconscious bias as a factor in "the under diagnoses of affective disorders and overdiagnosis of psychotic disorders' in racialised minority groups" (Merino et al 2018). Biases can manifest in both acts of commission and omission.

2.1.1 Institutional racism

MacPherson defined institutional racism as 'The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racial stereotyping' (Macpherson 1999). This definition suggests that attention is paid to structures and processes that disadvantage racialised groups, including acknowledging

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that social and economic inequalities reflect power and histories that created advantages for people of European heritage. Furthermore, this definition recognises that structural factors and institutional processes that result in poorer education, poverty, social isolation disproportionately impact racialised people prior to, during and after contact with mental health services are not accidental.

For example, Metzler (2010) in *Protest Psychosis* outlined how in the USA, the diagnosis of schizophrenia was influenced by occurrences in wider society. Specifically, how the use of the diagnosis changed over time from being a condition primarily diagnosed among white, middle-class women to Black men in urban setting. He was particularly cognisant of the changes in psychiatric journal articles, pharmaceutical advertising and the inclusion of hostility and excitability as diagnostic characteristics in DSM III around the time of the Civil Rights movement and the increase in racial politics in America: "Meanwhile, the image of schizophrenia in the USA generally was transformed in the 1960s and 1970s from... a psychological reaction and splitting of the functions of personality to one of a disorder of 'masculinized belligerence'".

Much of the current evidence about the relationship between racism (at individual, societal and institutional levels) and health emanates from the USA. As highlighted in Section 3.4, research is urgently needed to strengthen the evidence base and develop responses to address racism and unconscious bias in mental healthcare. It is clear that current approaches are not working. For example, Bennett (2013) and Noon (2018) highlight the ineffectiveness of diversity training. This is at least partly because strategies like unconscious bias training attempt to tackle these issues at the individual versus service level. Failure to effect real and lasting change despite decades of policy and practice initiatives suggest that fundamental changes in approach to training, monitoring and evaluation are required if we are to deliver race equality in mental healthcare.

2.1.2 Evidence

Unconscious/implicit bias and mental health outcomes in people of Black African and Caribbean heritage

Social theorists have used implicit bias as a framework to explain the persistence of covert racial discrimination, which continues to be reported despite favourable shifts in explicit public attitudes over time (Sniderman & Piazza, 2002).

It has been suggested by some authors that people from minority ethnic backgrounds and people with mental health problems are regularly subject to negative implicit biases (Sue et al, 2007). However, the majority of empirical research in this area has focused on racial bias in physical health problems. These hypotheses have primarily been tested using variations of the Implicit Association Test (IAT), a forced-choice perceptual task in which the participant is primed with an image prior to choosing a positively - or negatively - valenced stimulus (Greenwald, McGhee & Schwartz, 1998). A participant's response and

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reaction time can be used to infer their unconscious attitudes towards a target group and may be tested for associations with their overt behaviours. Evidence of the IAT's psychometric properties are mixed. It generally demonstrates very good internal consistency (Cronbach's alpha 0.7 – 0.9) (Schnabel, Asendorpf & Greenwald, 2008), although its predictive validity is contested (Greenwald, Poehlman, Uhlmann & Banaji, 2009; Oswald, Mitchell, Blanton, Jaccard & Tetlock, 2013). There are also some concerns of susceptibility to extraneous influences (Nosek, Greenwald & Banaji, 2007; Rae & Olson, 2018) and social desirability bias (Karpinski & Hilton, 2001).

The most extensive study on this topic to date was a systematic review of 15 studies which investigated implicit racial/ethnic bias in healthcare professionals (Hall et al, 2015). These studies measured different types of implicit bias, including good vs. bad, compliant vs. noncompliant, cooperative vs. uncooperative and high vs. low quality of care. Overall, low-to-moderate effect sizes were found, demonstrating reasonable evidence of implicit racial bias among multiple healthcare professions, levels of seniority and training. Interestingly, in some of these studies the degree of implicit bias predicted discrete outcomes. In order of frequency, these included patient-provider interactions, patient outcomes, treatment decisions and treatment adherence. This effect was found despite explicit attitudes which often, as expected, suggested an equal preference for Black and white patients. Evidence for implicit bias was even observed in fields where well-established racial disparities in health outcome exist, such as in Thrombolysis treatment (Green et al, 2007) and pain management (Sabin & Greenwald, 2012). The systematic review findings were somewhat inconsistent, possibly due to differences in methodology and outcome measures, although it is difficult to speculate with the relatively low sample of studies.

Overall, the available evidence suggests a high prevalence of negative implicit attitudes towards people from minority backgrounds and a direct link between these attitudes and a clinician's treatment decisions. Although research in this area has rarely focused on the mental health perspective, many of the studies included in the review were conducted in health disciplines where people from ethnic minority backgrounds have significantly worse outcomes relative to the white population (Williams & Wyatt, 2015). Therefore, it is probable that these findings can be generalised to mental health inequalities. Notably, clinical experience did not appear to reduce the strength of bias (Hall et al, 2015). This underlines the relative stability of implicit beliefs and raises questions around the optimal approach to mitigate these biases in clinical decisions (Evans, 2008; Norman & Eva, 2010). A proactive approach is clearly needed, drawing from interventions which have successfully reduced implicit bias (Sukhera & Chahine, 2016; Peris, Teachman & Nosek, 2008) and improved cultural competency (Bhui et al, 2015; Chowdhary et al, 2014) among mental health professionals.

Unfortunately, this review found no examples of racial implicit bias research specific to mental health, using empirical methods. Other limitations of the present review include a predominant African/Hispanic American focus, with no biases towards Asian, non-

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American or immigrant minority groups studied. In future studies, robust analyses are needed to derive the specific pathways to behaviours and potential mediators of this effect, including other protected characteristics. It is not sufficient to merely establish that implicit biases are prevalent, as people will differ in their ability to suppress or compensate for them (Bargh, 1999; Devine, Plant & Amodio, 2002). Future studies should also incorporate longitudinal interventions to reduce negative implicit racial biases in healthcare, as there is little available evidence at present.

Interventions to improve health outcomes for Black African and Caribbean people with mental health problems

Most attention aimed at addressing unconscious bias has predominantly focused on reducing bias itself. This has often been in the form of unconscious bias and/or equality and diversity training. Such interventions in the UK lack any solid evidence-base that demonstrates a positive association with transforming patient experience, or attitudinal and behavioural change among staff. Moreover, evidence indicates that diversity training (Kalev, Dobbin, & Kelly, 2006) and unconscious bias training has minimal (Atewlogun et al, 2017) or even unintended, negative outcomes (Devine et al, 2012).

In the absence of any robust evidence-base on interventions designed to address unconscious bias increased emphasis must be afforded to reducing the impact of bias itself on access and outcome in mental health care.

Bhui et al's 2015 systematic review of interventions designed to improve access, engagement and outcomes for BAME people with mental health problems, found that a number of different approaches were effective in improving outcomes for BAME people including adapted cognitive-behavioural therapy; adapted psychotherapy; complex interventions that engaged with social systems and stepped care; interview techniques such as ethnographic and motivational interviewing techniques; behavioural activation with an adapted cognitive behavioural paradigm; information and training for patients to support them to negotiate the mental health system and telepsychiatry. Most of the studies were from the USA, conducted over a short period of time and only focused on depression and common mental disorders. One of their main messages was that patients and carers particularly valued their personal experience and journey through the system and gave a clear indication that the way professionals communicate and interact are as important as the intervention provided (Bhui et al 2015).

A growing body of evidence indicates efforts at reducing the effects of bias (eg reducing opportunities for discretion, increasing time and focus for decisions), have resulted in improved outcomes. Heightened accountability is one component that has the potential to reduce the impact of bias that can be transferred onto the provision of mental health services. There is a wide range of decision-making points where oversight ranges from high to minimal. Increased monitoring in these areas is one way of increasing

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accountability. Increased scrutiny, linked with sanctions and incentives described by the Patient and Carer Race Equality Framework (PCREF), is another mechanism through which accountability can take place. A further approach to heightened accountability would involve increasing the role and scope of advocacy provision that is specifically attuned to understanding how race and racism can permeate decision-making. Our recommendations are aimed at changing the way in which services are delivered such that they are more acceptable to those most likely to be in need of them. Working to these recommendations will result in people from Black African and Caribbean heritage being less likely to attend mental health services when they are in crisis. They are more likely to receive treatment that is ethically sound, adheres to legal requirements and is more cost effective.

2.2 Economic impact of disproportionate detention of Black African and Caribbean people under the Mental Health Act

Very little work has been done on the economic impact of health inequalities in the UK, however, in the USA, it has been found that reducing racial disparities in mental health care led to savings in acute mental health and general medical care. For Black and Hispanic people, the potential savings brought about by eliminating disparities in inpatient general medical expenditures are as much as \$1billion (Cook et al 2015).

Clearly, improving access to care and improving outcomes will reduce health utilisation costs in this group and will reduce welfare costs as people are more likely to become and remain economically active and increase tax revenue for the same reason.

Mental Health Act detentions are also associated with a significant cost. The disproportionate rate of detention of people from Black African and African Caribbean backgrounds represents a very specific health inequality which is associated with significant costs to the individual; society and economic costs.

Black people are four times more likely to be detained under the Mental Health Act (MHA) than white people, ie 272/100k compared with 67/100k respectively. Approximately 9% of people detained under the MHA in 2015/16 were of Black African or Caribbean heritage. This is three times the percentage in the general population. Black people are also disproportionately represented in secure care. 12% of people in medium security and 18% of people in low security are Black, ie 15% of patients across low and medium secure settings are of Black African or Caribbean heritage. This is five times the percentage of Black people in the general population. In 2015/16, 49% of Black people who were admitted to a mental health hospital, were detained under a section of the MHA at some point during their admission. Black people tend to be admitted to the higher end of psychiatric services, such as intensive care and secure care and are therefore more likely to have longer admissions.

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The costs of a voluntary admission are £12, 535 (based on unit costs of £407/day for an average 30.8-day admission). The basic costs of detention under the MHA have been estimated to be ~£18, 315 per average 45-day admission. The average cost of a secure service admission is £165k per year, not including additional nursing and escort costs. With the national average length of stay being 709 days, an average admission to medium secure services costs in the region of £320k. These are conservative estimates and do not include the costs of economic inactivity or the later costs of welfare support.

In 2016, 4,400 people of Black African and Caribbean heritage were admitted under the MHA. Of these, it is estimated that 255 (15% of 1,696) were detained under part III of the MHA. Using the conservative estimates above, the basic costs of detaining these 4,400 people of Black African and Caribbean heritage was ~£158 million. Civil detentions of Black African and Caribbean people cost ~£75.9 million, detentions under part III of the MHA cost ~£42 million per year.

If the rates of detention in Black people were same as those in white people, ie 67/100k per year, then this would mean that approximately 1,125 rather than 4,400 Black people would be detained under the MHA per year. If the rates of detention under part III of the MHA were proportionate to the percentage of Black African and Caribbean heritage people in the population, 3%, then the overall cost of detaining Black people each year (including both part II and part III detentions) would be in the region of £28 million.

The minimum saving associated with reducing the disproportionate rate of detention of people of Black African and Caribbean heritage would be approximately £130 million per year.

3. Recommendations

Our thinking coalesced around the realisation that trying to change individual factors would not sufficiently address the inherent structural and institutional factors which contribute to the disproportionate rates of detention and the poorer mental health experiences and outcomes in people of Black African and African-Caribbean heritage. We focused on recommendations that we felt would support system change, be embedded into the fabric of mental healthcare delivery and sustained over the long-term. These will improve access, experience and ultimately mental health outcomes for people of Black African and Caribbean heritage. These range from recommendations to improve access and engagement, data collation and analysis, experience of services and workforce.

3.1 Organisational competence

3.1.1 Issue

The Equality Act 2010 protects people with protected characteristics against different forms of discrimination.²

The duty that applies to all public bodies listed in the Equality Act, including NHS Commissioners and providers, and to all organisations carrying out public functions is the **public sector equality duty** (s149).³ This duty is discharged by having “due regard” to the following three aims each time an option, policy or practice is introduced and each time its impact is assessed and reviewed:⁴ **Where adverse impact is detected having considered these three aims, public bodies need to consider whether there are ways they could reasonably mitigate that impact.**

- The need to put an end to unlawful discrimination, harassment, victimisation or any other conduct prohibited by the Equality Act.
- The **need to advance equality of opportunity between people who share a protected characteristic and those who do not**. This will involve having “**due regard**”⁵ to the need to remove or minimise disadvantages suffered by people due to their protected characteristics, take steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people, and encourage people with certain protected characteristics to participate in activities where their participation is disproportionately low.
- The need to **foster good relations** between people who share a protected characteristic and those who do not. This includes tackling prejudice and promoting understanding between people from different groups.

Public bodies are struggling to fulfil their public sector duties under the Equality Act 2010. The guidance provided thus far has been insufficient to do this. Given the ongoing disproportionately low rates of Black African and Caribbean people receiving mental health

² For further information, see EHRC introductory text here: <https://www.equalityhumanrights.com/en/equality-act/equality-act-2010>

³ See EHRC introductory guidance here: <https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty>

⁴ This is taken from the public sector equalities duty contained in s.149 Equality Act 2010; each of these three are objectives to which public authorities have to have regard to in specific contexts.

⁵ See EHRC guidance which states that “due regard” requires the relevant body to have made itself fully aware of and fully understand what the equality duty requires and this knowledge must have been put into practice.

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treatment in non-hospital and community settings; the low uptake of community mental health care; disproportionately high rates of detention and greater likelihood of detention in intensive care and secure settings, this group of people suffer ongoing disadvantage related to the protected characteristic of race. Nor can the protected characteristic of race be understood in isolation as the differential experiences of Black, Asian and Minority Ethnic communities, particularly those of Black African and Caribbean descent, can be viewed from the intersectionality of Equality Act protected characteristics operating with socio-economic factors to create a profoundly different experience resulting in exclusions and detentions.

3.1.2 Recommendations

Work to date has focused on methods for addressing systemic injustices in relation to the experiences of people of Black African and Caribbean descent who receive treatment under the Mental Health Act. There is wide-ranging support for a framework to hold local systems to account more robustly, to improve overall outcomes for Black people, bringing the perspective of patients and carers to the centre of service-led quality improvement agendas – directly correlated to the aims of the Patient and Carer Race Equality Standard, as outlined by the Crisp Commission.

Recommendation 1a:

- An **organisational competence framework (the PCREF)** should be developed and tested by Government, NHS England and other relevant arm's-length bodies. The framework should hold local systems to account more robustly to improve overall outcomes for Black people and other minority ethnic groups, bringing the perspective of patients and carers to the centre of service-led quality improvement agendas.
- In addition, a **patient and carer rated experience tool** should be developed as part of the PCREF which will form one of the main methods of measuring improvement and quality in services. The experience tool is a key component of the PCREF.

Recommendation 1b:

- Regulatory bodies such as the Care Quality Commission (CQC) should use their powers to support improvement in equality of access and outcomes. The EHRC should make use of their existing legal powers to ensure that organisations are fulfilling their Public Sector Equality Duty.

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3.1.3 Rationale

The PCREF is a **practical methodology that supports services to improve by helping organisations to understand how to improve and incentivises and measures attainment against set levels of service**. The PCREF is practical and aids the delivery of improved care using a **quality improvement approach** that is tailored to each local area.

It is important to note that the PCREF will **support organisations, potentially including public sector organisations beyond the health system, to fulfil largely existing obligations under the Equality Act** (such as their [Public Sector Equality Duty](#)) and to collect and use data efficiently and effectively. Equally important is that the experience of the PCREF can be exploited beyond the health system. A similar approach can be used by other public sector bodies to support their obligations under the Equality Act 2010 – something particularly relevant to the crossover with, for example, the criminal justice system in relation to the Mental Health Act.

An outline of an example organisational competence framework is attached at Annex 1. It shows how a provider or commissioner of services can develop their offer over time to enhance the mental health care delivered to people from BAME backgrounds. It is expected that this would be done in an incremental way that follows an iterative process, similar to a maturity matrix, allowing cultural change to be embedded into the mental healthcare delivery system. An incentive for change in the example is the use of additional funding, but different drivers and levers could be utilised to facilitate implementation of the PCREF, eg showcasing and publication of those services which fulfil Level 1 criteria.

3.1.4 Evidence and analysis

The Crisp commission's [Old Problems, New Solutions report](#) (2016) made a recommendation to identify a clear and measurable set of Race Equality Standards for acute mental health services – the Patients and Carers Race Equality Standard (PCRES), which they suggested should be developed to test whether the Workforce Race Equality Standard (WRES) is having the desired effect of improving services.

This was endorsed as part of the 2016 [Five Year Forward View for Mental Health](#) (FYFVMH), particularly in light of persistent inequalities in early intervention and crisis care, rates of detention and lengths of stay in secure services following the end of the five-year Delivering Race Equality (DRE) programme in 2010.

In 2014, the Joint Commissioning Panel for Mental Health (2014) issued guidance around the commissioning of mental health services for BAME people. This guidance drew on the findings and recommendations from the DRE programme and attempted to outline what good mental health services for BAME people should look like. In response to DRE and other guidance, some areas developed initiatives aimed at improving outcomes for BAME groups, however, these projects have not been sustained or were side-tracked, with BAME

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issues no longer being the main focus of their work eg The Revolving Door Project in Birmingham and Solihull Mental Health Foundation Trust, Community Development Workers.

The DRE was successful in raising awareness of race inequality issues in mental health and in encouraging the development of initiatives to support equality of access and outcome, however these initiatives have not generally embedded in mainstream services. Over the years there has been insufficient improvement in outcomes for BAME people, particularly with respect to detention under the Mental Health Act.

3.1.5 Implementation considerations

A system of incentives, levers and drivers should be developed with relevant arm's-length bodies, such as NHSE or the Local Government Association and other stakeholders to facilitate adherence to and delivery of the PCREF. This may require additional powers (and resource) to enable the CQC to pay attention to individual cases and undertake appropriate sanctions (possibly at individual ward level).

Initial development and setup costs are likely to be borne within existing NHSE programme budgets under the FYFVMH – work is ongoing with National Collaborating Centre for Mental Health as part of the Advancing Mental Health Equalities programme. The most substantial additional cost burden will be funds to support potential service-facing support and/or incentives. These may fund service development and/or reward areas for outstanding attainment.

Any investment in incentives should be offset by reduced demand for services at the point of mental health crisis. We currently do not have any indicative figures for the operationalisation of a PCREF model. Ongoing conversations with NHS England (NHSE) and the National Collaborating Centre for Mental Health (NCCMH) may elicit further specifics over the coming months, but until the scope is agreed and a refined model is developed, we will struggle to outline more detail.

It is important to note that the work of MHARAC has focussed solely on the needs of African and Caribbean individuals in relation to mental health crisis and subsequent detention under the Mental Health Act. The PCREF is a methodology that should be sufficiently flexible to respond to the needs of any populations, regardless of its racial makeup, as well as all public services – not just the health profession. In order for the PCREF to have greatest impact, therefore, it needs to be sufficiently aligned with existing legislation through the Equality Act. However, given the vital importance of its applicability to mental illness, potential legislative reform to the Mental Health Act may incorporate a duty for commissioners and providers of services to have due regard to the PCREF as the means by which to fulfil existing obligations under the Equality Act. Further consultation with lawyers will be necessary to determine the legislative options to do so.

3.2 Culturally-appropriate advocacy

3.2.1 Issue

People of Black African and Caribbean heritage experience mental health services more negatively than other ethnic groups. This differential experience likely reflects the unconscious bias and institutional discrimination which are also encountered in broader society. As mental health services may compound the unequal status afforded to Black African and Caribbean people, advocacy can be instrumental by establishing a better foundation for appropriate care and treatment.

3.2.2 Recommendations

The group endorse the recommendations from the Advocacy topic group in relation to improved access to Independent Mental Health Advocacy (IMHA) services via an opt out approach; expanded eligibility for IMHA provision to informal patients (including those in prison), and those discharged on s117; and the need for more comprehensive training (including the addition of cultural community placements) and oversight to ensure sufficient quality of advocacy services.

However, the specific needs of individuals of Black African and Caribbean heritage from the point of contact with services necessitates the involvement of a race-specific advocate, potentially in addition to regular IMHA services.

Recommendation 2: Culturally-appropriate advocacy should be provided consistently for people of all ethnic backgrounds and communities, in particular for individuals of Black African and Caribbean descent and heritage.

3.2.3 Rationale

Culturally-specific advocacy is a proportionate means of addressing the legitimate aim of improving the inordinately negative relationship between people from Black African and Caribbean backgrounds and mental health services.

National and international research has illustrated the valuable role of advocacy. This includes providing a greater sense of well-being, self-efficacy and empowerment. Relationships between services have also been positively impacted with increased levels of trust and more positive engagement. Advocacy has also led to improvements by reducing the risk of future detention, improving attendance in aftercare, and patient experience in detention (McKeown, et al, 2014; Newbigging et al, 2014).

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Large-scale advocate organisations bring with them a profile, reputation, and an established funding base which in-turn offers benefits to commissioners when administering commissioning contracts. This approach needs to be re-thought and re-considered. There is evidence that culturally-specific organisations bring social capital and are more effective at increasing uptake amongst racialised minority people (Newbigging et al 2008).

There is a desperate need for high-quality culturally-specific advocacy to ensure that people from African and Caribbean backgrounds receive appropriate representation, care and treatment (Social Care Institute for Excellence, 2008). This should involve a balanced approach to service delivery that focuses on self-determination, participation as well as safeguarding rights.

Culturally-specific advocacy can assist in opening and building relationships as there is a common ground based on shared identity. Culturally-specific advocacy is however much more than shared identity. This involves a sharper and shared understanding of racialised issues, and detailed knowledge of anomalies in care and treatment of Black people in mental health services.

Culturally-specific advocacy can assist in addressing the disproportionately negative experiences of Black African and Caribbean people in health services which are informed by broader societal inequalities. This is of significance when Black African and Caribbean people are subject to greater levels of surveillance, control and discrimination, which confer disadvantage and are experienced as abuse. Culturally-specific advocacy is a proportionate approach to help reduce the likelihood of people experiencing mental health services as abusive and to ensure that disenfranchised voices are better heard, and dignity is upheld.

3.2.4 Evidence and analysis

Monitoring of IMHA utilisation has been poor and service development has been patchy and inconsistent whilst uptake has been markedly lower among BAME people (Foley & Platzer, 2007; Newbigging et al, 2014).

A pattern of low rates of IMHA take-up has been documented in inner city area areas (19%) with higher rates in secure care (92%). However, there are concerns that the available Advocacy is not meeting the culturally specific needs of Black people in secure settings. Data suggests that IMHAs are not representative of the service-user population (three quarters are white women) which limits advocate choice. Furthermore, there is an identified gap in service provision for racialised minority people as a result of the scarcity of culturally-appropriate services (Newbigging et al, 2014; Hakim & Pollard, 2011).

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Research suggests there is minimal recognition of the important role, and a lack of adequate resources, for culturally specific advocacy services (Rai-Atkins et al, 2002, Newbigging et al 2007; 2011; 2014).

Generic advocacy support is poor at proactively engaging racialised minority people (Newbigging, McKeown & French, 2011). Combined with the lack of trust Black people have in mental health services, and the lack of awareness about advocacy support, an appropriate approach is needed to improve service engagement.

The mainstream model of advocacy has evolved and emerged based on the needs of white service-users and is delivered predominantly by white advocates (Social Care Institute for Excellence, 2008). It does little to recognise the adversarial pathways Black people take towards services or the experience of double discrimination on the grounds of race and mental illness. Mainstream advocacy is also based on individualistic and narrow conceptualisations about the needs of Black people. This contributes to a colour-blind approach that is not grounded in understanding or addressing the unique and specific concerns of Black African and Caribbean people.

Feedback from focus groups hosted by MHARAC raised a number of important points:

- Certain carers were unaware of the role of mental health advocacy and its applicability to their situation.
- Service users flagged an inability to actively request an advocate at the point of being admitted to hospital.
- Approved Mental Health Professionals (AMHPs) supported the notion that advocates should play a greater role at the start of the assessment process, particularly if police interaction plays a part.
- There was also a suggestion that AMHPs are often well-placed to take on the role of an advocate on behalf of the service user and family

3.2.5 Implementation considerations

Further pilots will need to be undertaken, based on the outputs and feedback from current pilots such as the Birmingham secure care programme. The commissioning of specific advocates to cater for the needs of particular individuals, over and above current IMHA provision, is likely to have significant additional resourcing and financial implications. However, the potential for reduced length of stay, and less revolving door experiences, could outweigh any upfront development.

3.3 Workforce

3.3.1 Issue

The current workforce, within health services and more widely, often fails to reflect the population makeup of a certain area. This may result in a subsequent lack of cultural understanding resulting in a greater likelihood of implicit or explicit bias playing a role in decision making, particularly in relation to Black African and Caribbean individuals. In mental health services, this may be especially important when it comes to treatment decisions, which influence decisions around detention under the Act. There is good evidence that Black African and Caribbean people, particularly men, do not have access to psychological treatment at an early stage of their health problem and there is a lower rate of Black African and Caribbean people being offered IAPT services. If they are offered these services they are more likely to drop out. It is of note that the majority of IAPT services are staffed by young psychology graduates, who are for the most part (~90%), from white backgrounds. This may introduce a number of barriers to being offered, accepting and receiving appropriate care. The differences in access to IAPT services is currently being researched at University College London, but the stark disparity between who is offering the treatment and who is unlikely to receive it is hard to ignore.

Over the years, across the mental health workforce there have been changes in the ethnic make-up of staff, in particular within the nursing and psychiatric professions. There remains a significant underrepresentation of staff of Black African and Caribbean heritage in the psychology and occupational therapy professions. This is key as these professions are primarily responsible for the delivery of non-pharmacological treatments. In the medical profession, BAME staff are well represented, but closer scrutiny shows that many medical staff are from Asian backgrounds and thus may have little in common culturally with Black African and Caribbean service users, other than a shared experience of perceived racism. It is well recognised that racialised groups are frequently subject to different stereotypes, which may be internalised. Being from a racialised minority does not in and of itself reduce the likelihood of behaving in a discriminatory way towards other racialised minorities. Most importantly, the institutional factors which exist may mean that even the presence of those from similar cultural backgrounds might not be able to mitigate against the structural factors that propagate the disadvantage that exists for Black African and Caribbean people in mental health services.

The lack of Black African and Caribbean people at senior levels of their profession (particularly managers, doctors, psychologists, social workers and researchers), means that there is likely to be less attention paid to the difficulties faced by this particular group. For the minority of individuals from Black African and Caribbean backgrounds at the top of their professional tree, it must be very difficult to make changes alone without fundamental changes to how the mental health system, education system and criminal justice system are run.

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3.3.2 Recommendations and rationale

Recommendation 3a: In line with the NHS Workforce Race Equality Standard programme, greater representation of people of Black African and Caribbean heritage should be sought in all professions, in particular psychology and occupational therapy.

Recommendation 3b: People of Black African and Caribbean heritage should be supported to rise to senior levels of all mental health professions, especially psychiatry and psychiatric research, psychiatric nursing and management.

It is imperative that school children are encouraged to consider mental health as a career. For this to happen, early exposure to the possible professions within mental health is crucial. In particular there should be encouragement and support to become psychologists and occupational therapists. The universities should work with schools specifically around encouraging Black African and Caribbean children to take up psychology and occupational degrees.

Recommendation 3c: Behavioural interventions to combat implicit bias in decision-making should be piloted and evaluated.

Good quality training which helps to develop understanding about implicit bias should be a standard part of the curricula for all those professions who will come into contact with people with mental health problems, including the police, ambulance service, and those in education. Professional training must include an understanding of the importance of collecting data about the demographics of the local population being served, analysing needs of the local population and how to develop services which respond to the needs of that population. Arm's length bodies responsible for setting standards in training and determining curricula content should ensure that training around implicit bias is a core part of training and that professionals cannot qualify without demonstrating good understanding of this.

3.3.3 Evidence and analysis

In order to illustrate the current ethnic composition of the mental health workforce, this short review presents the available statistics for the following professions: psychiatry, clinical psychology, occupational therapy, social work and mental health nursing. To the authors' knowledge, all ethnicity reports were self-determined. All statistics were calculated without taking into account missing data, therefore the figures cited below may differ slightly from those presented in their respective source. Where possible, we have also investigated ethnic disparities across time and levels of seniority, in addition to the experiences of BAME professionals. For reference, the 2011 census estimated the working age population of England and Wales to be 85.6% white (79.2% White British), 8.1% Asian, 3.4% Black, 1.8% Mixed and 1.1% from an 'Other' ethnic group (Office for National Statistics, 2012).

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Psychiatry was the most diverse of the mental health professions studied, 61.35% of members and fellows reported being of white European heritage, compared to 38.65% BAME (The Royal College of Psychiatrists, 2018) (See Table 1). These statistics do not precisely reflect the current psychiatry workforce, as retired psychiatrists may retain their membership. The proportion of BAME psychiatrists decreased at higher levels of seniority, with an estimated 22.28% of fellows reportedly from a BAME background. BAME psychiatrists were more likely to be male, both overall and at senior levels. Although the psychiatry workforce is very ethnically diverse, the majority of BAME doctors are Asian and the majority of the Black doctors are from African rather than Caribbean backgrounds. The proportion of Black doctors is greater than the proportion of Black African and Caribbean people in the general population, but far less than that seen in the clinical population. It is unclear how psychiatry rates compare to the medical profession as a whole, as there were no comparable statistics available for the year 2017. However, in 2014 40.3% of medical grade staff were reportedly from a BAME background, which reduced to 34.8% at consultant grade (NHS Digital, 2015).

Members and fellows				Fellows			
Ethnicity	All	Female	Male	Ethnicity	All	Female	Male
Asian	26.96%	23.66%	29.79%	Asian	14.95%	11.54%	16.35%
Black	4.48%	3.42%	5.40%	Black	1.99%	1.17%	2.33%
Chinese	1.02%	1.12%	0.94%	Chinese	0.24%	0.67%	0.07%
Mixed	1.96%	2.42%	1.56%	Mixed	1.31%	0.84%	1.50%
Other	4.23%	3.72%	4.67%	Other	3.79%	2.51%	4.31%
White	61.35%	65.66%	57.64%	White	77.72%	83.28%	75.44%
BAME	38.65%	34.34%	42.36%	BAME	22.28%	16.72%	24.56%

Table 1. Demographic statistics for members and fellows of the Royal College of Psychiatrists.

Nursing was the second most diverse mental health profession. In 2008 (the most recent figure available), 30% of successful mental health nursing applicants identified as BAME, although we have been unable to ascertain the effect of withdrawal of the nursing bursary on applications from BAME students since then. Nonetheless, across all nursing specialities, the proportion of applicants from BAME backgrounds across all nursing specialities rose from 25-35% between 2009 and 2017. Despite these encouraging

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findings, some inequalities were also identified, primarily in terms of working conditions. BAME nursing staff were more likely to work full-time (79% cf. 69%); were more likely to be dissatisfied with their pay conditions; were more likely to work additional hours, and reported higher levels of physical abuse, relative to their white counterparts (Royal College of Nursing, 2017). BAME staff were more than three times as likely to work an additional 10 or more hours per week, and only half of those nurses who worked additional hours reported that they were financially reimbursed. Finally, despite the large number of BAME staff, there is some evidence that mental health nursing teams rarely match the demography of their local population (Bowers, Jones & Simpson, 2009). This may be attributable to the relatively high proportion of Black African nurses, relative to other ethnic minorities.

Social work was also more diverse than the general population, with 2016/17 figures estimating that 80.0% of local authority social workers were from a white background, 10.6% Black, 5.2% Asian, 3.1% Mixed and 1.1% Chinese or other (Office for National Statistics, 2018). Between 2010/11 and 2015/16, there was a 6% increase in BAME people enrolling onto social work courses, from 26% to 32% (Skills for Care, 2018). This was the greatest increase seen amongst the mental health professions, and substantially greater than the average enrolments across higher education (22%). As of 2011/12 (the most recently available figure), there were no ethnic differences in qualifying rates for social work courses.

Occupational Therapy was one of the least diverse of the mental health professions. In 2017, an estimated 90% of occupational therapists were from a white background, compared to 10% from a BAME background (Skills for Care, 2018). This is substantially higher than in 2014, when BAME representation was approximately 6.4% among occupational therapists in the NHS (NHS Digital, 2015) (not including the 16% of occupational therapists who work outside the NHS). BAME representation in this area is likely to increase in the near future, as in 2013/14, 16% of new occupational therapy students were from a BAME background. There was no available breakdown for mental health occupational therapists.

Clinical psychology was the least diverse mental health profession. As of September 2014 (the most recently available figure), 9.5% of qualified clinical psychologists were reportedly from a BAME background (NHS Digital, 2015). Approximately 90.5% of qualified psychologists classified themselves as White, 4.6% as Asian (including Chinese), 1.7% as Black, 2.1% as Mixed, 0.9% as 'Other'. BAME representation was slightly higher among NHS psychotherapists (12.3%) (NHS Digital, 2015). Psychotherapists also require postgraduate level training which, unlike the clinical doctorate, is self-funded. The route to doctoral training can be particularly convoluted and lack transparency. There is a requirement that applicants have adequate clinical experience but this may have to be undertaken voluntarily. This may disadvantage people who are poorer or those from BAME backgrounds who may not have the contacts within psychology to support them to

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gain access to a psychological practice placement. Relative to 2011, a higher proportion of BAME people applied to study clinical psychology at doctoral level (15.5% to 18.0%) and a higher proportion of successful applicants were from a BAME background (8.2% to 10.8%), based on 2017 estimates (Clearing House for Postgraduate Courses in Clinical Psychology (CHPCCP), 2018). We have requested raw data from the CHPCCP, in order to analyse these demographics in more detail. There is no available ethnic breakdown for senior level (consultant) clinical psychologists.

As of 2018, 14% of NHS board-level positions in London were occupied by someone from a BAME background (The King's Fund, 2018), with a previous study finding two fifths of trusts lacking any BAME board level representation (Kline, 2014). Senior management across the entire adult social care workforce was less diverse, with an estimated 17% BAME representation, compared to 83% BAME representation for all adult social care roles (Skills for Care, 2018). This suggests some barriers to promotion among BAME workers, although we are unable to estimate the degree of this for each profession.

Considering the available evidence, our findings clearly indicate a lack of ethnic diversity within some mental health professions, which is consistently more apparent at senior levels. This lack of diversity has been reflected upon in the experiences of various BAME professionals, who may feel a responsibility to provide a cultural perspective where it may otherwise be absent (Saha et al, 2000; Smith & Cabral, 2011; Shah, 2010; Odusanya, 2018). Some ethnic differences in working tendencies were also observed which, to an extent, may reflect wider societal inequalities. Unfortunately, the present review was limited by absent or poor-quality data, which must be addressed by the Workforce Race Equality Standard (WRES). Potential areas of study not covered by this review, but worthy of consideration include the intersectionality of race with other protected characteristics (Crenshaw, 1989); demographic concordance between staff and local populations (Bowers, Jones & Simpson, 2009); decision making for role appointments and the white-BAME student attainment gap (Department for Education, 2015).

3.3.4 Implementation considerations

Development and delivery of additional training will have associated costs and will need to be piloted in certain areas/professions, before wider rollout. However, a focus should be placed on relevant, effective, coproduced content and delivery of training over and above unnecessary development of additional training packages and toolkits. The need for cultural competence to be addressed before qualification is vital, and funding/support should be given to academics to build the evidence base through robust study designs.

The ultimate aim is to encourage better decision making in relation to ethnicity at all parts of the pathway, whether during detention or otherwise. Behavioural change in the existing workforce, as well as any improvements in the cultural competence of the future pipeline, may helpfully be influenced through the adoption of certain elements of 'nudge theory'.

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Conversations with the Behavioural Insights Unit are ongoing, with potential subtle changes to standard clinical paperwork offering possible options to ensure ethnicity is adequately considered alongside other factors at key decision-making points. Again, any such interventions would require small-scale piloting before wider rollout.

3.4 Data and research

3.4.1 Issue

- Interventions – very little information on what works for Black African and Caribbean patients.
- Little information (rates and/or interventions) on other types of mental health problems other than psychosis for Black groups.
- Where information exists, it suggests under-estimation of prevalence/incidence of Common Mental Disorders such as anxiety and depression and lack of access to psychological therapy.

3.4.2 Recommendations

Recommendation 4a: Data and research on ethnicity and use of the MHA should be improved, with all decisions being recorded and reviewed consistently by organisations involved in the process – in particular criminal justice system organisations and Tribunals.

Recommendation 4b: Funding should be made available to support research into i) the issues that lead to mental disorder in people of a wider range of ethnic minority communities, in particular African and Caribbean individuals; and ii) interventions which improve outcomes.

3.4.3 Rationale

- Research around MHA detentions consistently shows higher levels of detention in Black people.
- Research around MHA detentions frequently provide explanations which are not backed up by evidence and are thus flawed. These flawed explanations are repeated in replicated research resulting in a continued lack of understanding of the factors that may be driving the high rates of detention under the MHA for Black African and Caribbean people.

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- The flawed explanations, which are very prevalent in this area of research, may have resulted in a lack of focus on research around interventions which might work to improve outcomes for Black African and Caribbean people.
- The research that is done, even that which is of very high quality, frequently groups together culturally disparate Black people and ascribes to them particular characteristics and outcomes. Although there may be methodological reasons for this, in and of itself, this introduces structural errors into the research which mean that the outputs of the research will necessarily be flawed.
- There is a need for a reset of research into Black mental health. It is imperative that the research is of high quality but above all that the conclusions reached are reviewed in light of new evidence that these may be driven by structural factors which are inherently biased against African and Caribbean people.
- Mainstream psychiatric research has rarely included input from Black African and Caribbean researchers and/or service users. It is likely that the input of researchers from African and Caribbean backgrounds will improve the quality and specificity of the research questions asked and are likely to better focus on interventions which might help outcomes in this group.
- It is imperative that senior researchers support researchers from Black African and Caribbean backgrounds to develop high quality research skills so as to ensure that better research is done in this area. It is recognised that this will take some years to develop high quality researchers, but current academics from Black African and African Caribbean backgrounds should be supported to design high quality research in this area. There are few funding calls for research which specifically focuses on improving mental health outcomes for Black people.

3.5 Adverse childhood experiences

3.5.1 Issue

Antecedents to mental ill-health in Black African and Caribbean people include a number of individual factors, including the influence of birth difficulties, early trauma and familial factors (genetic and environmental). This effect is compounded by the influence of wider societal factors, including overt racism and structural racism, including negative media representations of Black people throughout childhood. Perceived discrimination has been recognised as an antecedent to both psychological and physical ill-health in Black African and Caribbean people, increasing the likelihood of developing psychiatric conditions later in life and possibly contributing to the maintenance of psychological disorder (Pascoe and Smart Richman 2009; Pieterse et al 2012). This perceived discrimination is increasingly

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being recognised as being traumatic for some individuals and produces stress responses similar to those seen with other traumatic events (Clark et al 1999). The recognition and elucidation of this trauma may help to unlock some of the understanding around the increased likelihood of psychological difficulties in Black African and Caribbean children and young people. All children who experience trauma are at higher risk of developing mental health problems, however, it is likely that Black African and Caribbean children, boys in particular, are subject to greater adverse childhood experiences than other children and young people. This is reflected in the findings that:-

- Children of Black African and Caribbean descent are more likely to be referred to Children and Adolescent Mental Health Services (CAMHS) via education, social or other services (the compulsory route) rather than primary care
- Black African and Caribbean boys have high rates of referral to CAMHS for conduct disorder and Attention Deficit Hyperactivity Disorder (ADHD).
- Black Caribbean pupils are three times more likely to be excluded from both primary and secondary school than white British boys

All the above findings are highly likely to be linked. Conduct disorder and ADHD are usually related to familial factors and the possibility that there is a greater prevalence of risk factors for these disorders in Black families needs to be investigated further. However, there are concerns that stereotyping of young Black male children means that their emotional distress is viewed as conduct problems, requiring sanction, rather than emotional problems requiring mental health support. This would go some way to understanding the high rates of school exclusion in younger Black children in particular.

Conduct disorder and ADHD are associated with an increased risk of substance misuse. Substance misuse is associated with an increased risk of mental ill-health later in life and involuntary detention.

The fact that boys of African and Caribbean descent are more likely to be excluded from school and to be diagnosed with conduct disorder and/or ADHD is a major public health problem and should have stimulated a wider response. There are significant links between conduct disorder, ADHD, poor educational outcomes and later contact with the Criminal Justice System, and thus there should be urgent intervention to address this problem. The lack of response speaks to the likelihood of institutional factors coming into play as this indicates 'a collective failure...to provide an appropriate and professional service' (MacPherson 1999).

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3.5.2 Recommendations

Recommendation 5: A call for research should be made into tailored early interventions for Black African and Caribbean children and young people, particularly those at risk of exclusion from school.

3.5.3 Rationale

Ongoing programmes to improve mental health services for children and young people, such as [Transforming children and young people's mental health provision: a green paper](#), make positive steps towards improving early identification and intervention, both within schools and the NHS. However, the current proposals do not respond to the specific needs of Black African and Caribbean individuals, despite the proportion who may be clearly on the trajectory to worse life outcomes.

The proposals in the green paper need to be revised to take into account the specific needs of children and young people from Black African and Caribbean backgrounds. Feedback from service users, carers and professionals highlighted recurrent trauma in the lives of young Black people. Interventions already exist for helping children and families who have been traumatised. In addition, parenting training has been developed to support parents of traumatised children. These existing interventions need to be reviewed and where necessary modified or developed to address the needs of Black African and Caribbean people.

Investment in early intervention will reduce the likelihood of Black African and Caribbean children and young people being excluded from education; will reduce them developing more intractable emotional and conduct difficulties (including misuse of substances), and in the longer term reduce contact with the criminal justice system and health utilisation costs.

3.5.4 Evidence

3.5.4.1 Disadvantage, adverse childhood experiences and mental ill-health

There is minimal research looking into mental health problems, young Black people and trauma. Studies are increasingly identifying the importance of early life experiences to peoples' health throughout the life course. Individuals who have adverse childhood experiences (ACEs) during childhood or adolescence, tend to have more physical and mental health problems as adults than those who do not have ACEs (Hughes et al 2017). There is evidence that this ultimately leads to higher rates of premature mortality (Bellis et al 2014). ACEs include harms that affect children directly (eg, abuse and neglect) and indirectly through their living environments (eg, parental conflict, substance misuse, or mental illness). It is likely that Black children are exposed to more ACEs than their white

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counterparts and are therefore more likely to be at risk of mental health problems (VanHook 2012).

The Office of National Statistics (ONS) survey showed that the prevalence of mental health problems in children and young people varied depending on ethnicity. Around 1 in 10 white children had a mental health disorder, compared to just under 1 in 10 Black children, and 3 in 100 Indian children. More recent data from NHS Digital (2017), found that prevalence rates of behavioural disorders (oppositional defiant disorder and conduct disorder) were lowest in Black children (0.7%), compared with white children (5.7%) and Asian children (0.8%). Behavioural disorders often interfere with children's schooling and increase the risk of school exclusion. However, despite the lowest rates of behavioural disorders, Black children are more likely to be excluded from school than children from other ethnic groups, even very young Black children. Black Caribbean pupils had a permanent exclusion rate nearly three times higher (0.28 per cent) than the school population as a whole (0.10 per cent). Research from the USA suggests that African-American children and young people are considerably more likely to be exposed to risk factors for conduct disorder but are much less likely to be diagnosed with this disorder than their white counterparts. They are more likely to be criminalised than referred for therapeutic intervention when they display behavioural disturbance (VanHook 2012).

3.5.4.2 Impact of mental health problems in children and young people

[Transforming children and young people's mental health provision](#), outlined the following:-

“Children and young people with mental health problems are more likely to have negative life experiences which can damage their life chances as they grow towards adulthood. These are more likely to occur in those who have ACEs. These challenges include the fact that:

- *Children and young people with mental health problems are more likely to experience increased disruption to their education, via time off school and exclusions, than children with no mental health problems (Green et al 2005).*
- *Young people with mental health problems are more likely to experience problems in their future employment, with various longitudinal studies suggesting long-term impact on economic activity such as receipt of welfare benefits, income, and continuous employment (Goodman et al 2011).*
- *One quarter of boys in Young Offender Institutions reported emotional or mental health problems (HM Inspectorate of Prisons 2016).*
- *Young people with conduct disorder are more likely to engage in criminal activity, with research suggesting they are 20 times more likely to end up in*

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prison, and four times more likely to become dependent on drugs, compared to the general population (Khan et al 2015)."

Although children of Black African and Caribbean descent are least likely to be diagnosed as having a mental health problem, they are most likely to be excluded from school. School exclusion is a sign of poor functioning in childhood. A proportion of these children will have mental health problems that are not being recognised (NHS Digital 2018).

Research is needed to look into nature and true prevalence of mental health problems in Black African and Caribbean children and young people. As school exclusion is a measure of poor functioning in childhood, those who are excluded should be screened for mental disorder and interventions should be developed to halt the trajectory towards substance misuse, adult mental health problems and criminality. This will also support commissioning plans and service provision which appropriately meets the needs of children from Black African and Caribbean backgrounds.

4. Wider areas of interest

A number of further areas were discussed as part of MHARAC's work, which correlated with wider discussions across the review as a whole. We worked closely with particular topic groups dealing specifically with these issues to ensure that their recommendations take into account the needs of Black African and Caribbean people.

In line with the Organisational Competence Framework, our wider recommendations include:

- Raising the bar for individuals to be detained under the Mental Health Act, as well as any subsequent use of Community Treatment Orders.
- Providing the opportunity for people to have more of a say in the care they receive, ensuring that people from ethnic minority backgrounds are involved in the care and treatment plans developed for them and thus increasing the likelihood that they are more acceptable.
- Increasing the opportunities available to challenge decisions about the care offered and received in a more meaningful way.
- Reducing the use of coercion and restrictive practices within inpatient settings, including in relation to religious or spiritual practices.
- Endorsing ongoing work to explore how the use of restraint by police is reduced, encouraging police services to support people experiencing mental distress or ill health as a core part of day-to-day business.

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- Giving individuals the ability to choose which individuals from their community are involved with, and receive information about, their care.

4.1 Substance misuse, ethnicity and the use of the Mental Health Act

We also spent some time considering the issue of substance use in Black African and Caribbean populations, and the relationship of this to detention under the Mental Health Act.

4.1.2 Issue

There is strong evidence of an association between substance use and mental health problems, both in the genesis, the recurrence and the course and prognosis of mental health problems (see Annex 2 for overview of substance misuse and mental health problems). Barnett al (in review) conducted a systematic review which found that one of the frequent explanations given for the higher rates of detention in people from Black African and Caribbean backgrounds was the higher rate of substance misuse in this group. They found that there was little evidence to support this conclusion. We wanted to ascertain the impact of substance use given the frequent anecdotal reports of high rates of substance misuse in the Black population and this being linked to worse mental health outcomes.

4.1.3 Evidence

We scoped available evidence to address the questions below, raised by the MHARAC group. This involved searching for relevant evidence using databases and specific journals of relevance. This brief report provided a rapid scoping of available evidence for the Mental Health Act Review African and Caribbean Group (MHARAC). It does not provide a systematic review of available evidence, so may not be comprehensive.

We sought answers to the following questions:

- Is substance use higher in people of Black African and Caribbean descent?
- Is substance use higher in clinical populations from Black African and Caribbean backgrounds?
- Is substance use in people from Black African and Caribbean backgrounds associated with admission to hospital, in particular compulsory admission?
- What are the reasons for substance use in general populations of people of Black African and Caribbean heritage?

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- What are the reasons for substance use in clinical populations (people in receipt of mental health services) of people of Black African and Caribbean heritage?
- What are the clinical conditions associated with substance use in people of Black African and Caribbean heritage?
- What are the clinical conditions associated with substance use in people of Black African and Caribbean heritage?
- What are the rates of substance use service uptake for people of Black African and Caribbean heritage?

Is substance use higher in people of Black African and Caribbean descent?

Illicit drug use

There is mixed evidence as to the relationship between ethnicity and illicit drug use. Data from the most recent Adult Psychiatric Morbidity Survey (APMS), in 2014, found that the rates of drug use were higher in Black populations and that this higher rate was explained specifically by higher rates of cannabis use.

Ethnicity	Sex	Rates of illicit drug use in the last year	Rates of cannabis use in the last year
Black/Black British	Men	14.3%	14.3%
	Women	9.7%	9%
White British	Men	12%	9.4%
	Women	6%	5.1%
White other	Men	12%	10.1%
	Women	6.5%	6.9%
Asian/Asian British	Men	5.9%	5.1%
	Women	0.4%	0.3%
Mixed, multiple, and other	Men	8.5%	7.2%
	Women	6%	4.9%

Table 1: APMS (2014) rates of illicit drug use in the UK by ethnicity

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However, British Crime Survey data suggests that the highest rates are in mixed race minority ethnic groups with Black groups having the third highest rates, below white groups. It is suggested that this is perhaps driven by the mixed race group being a younger population and is also explained by higher cannabis rates (Beddoes et al, 2010).

Ethnicity	2006/07, 2007/08 and 2008/09 combined - Rates of illicit drug use in the last year	2017-2018 - Rates of illicit drug use in the last year
Black groups	5.8%	5%
White groups	10.5%	9.8%
Asian groups	3%	2.3%
Mixed race groups	17.6%	19%
Non white groups	N/A (category not used)	4.8%
Chinese or other	N/A (category not used)	4.2%

Table 2: British Crime Survey data combined 2006/07, 2007/08, and 2008/09 and 2017/18 on rates of illicit drug use

Alcohol use

Rates of alcohol use are higher in white populations.

Ethnicity	Sex	Rates of people scoring 8+ on AUDIT (indicating hazardous or harmful alcohol use)
Black	Men	6.6%
	Women	7.4%
White British	Men	30.8%
	Women	14.8%
White other	Men	18.4%
	Women	11.6%
Asian/Asian British	Men	4.7%
	Women	2.6%
	Men	12.9%

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Mixed, multiple, and other	Women	7.2%
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Table 3: APMS (2014) data on rates of hazardous/harmful alcohol use by ethnicity

Is substance use higher in clinical populations from Black African and Caribbean backgrounds?

Illicit drug use

The evidence is inconclusive. In a London Community Mental Health Team (CMHT) sample, Afuwape et al (2006) found that rates of dual diagnosis (specifically cannabis use) were higher for Black British-born patients compared to white patients ((18% vs 13%, OR 0.71 (0.53, 0.95) p=0.02) – results from further analyses of the Afuwape et al (2006) data conducted by Megnin-Viggars et al (2015)).

Conversely, Donoghue et al (2014) found lower rates of substance misuse for Black ethnic groups compared to White ethnic groups in a first episode psychosis sample. These discrepant results are also supported by the conclusion of a large systematic review which found that evidence was inconclusive as to whether Black patients are more likely than White patients to have dual diagnosis (Carra and Johnson, 2009).

Alcohol use

It appears that alcohol use is higher in the clinical white population. Afuwape et al (2006) found that in their London CMHT sample, there was a higher prevalence of alcohol use in the white group. This is further supported by analyses conducted by Megnin-Viggars et al (2015) who found that there were higher rates of alcohol abuse, a higher mean monthly consumption of alcohol in units, and higher mean score on the AUDIT, in the white group compared to the Black group.

Is substance use in people from Black African and Caribbean backgrounds associated with admission to hospital, in particular compulsory admission?

There is limited evidence that directly addresses this question. A recent NCCMH systematic review (Barnett et al, in review) found when reviewing 70 studies examining ethnic differences in rates of compulsory admission that there was no supporting evidence for drug use as an explanatory factor for the higher rates of compulsory admission among Black ethnic groups.

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What are the reasons for substance use in general populations of people of Black African and Caribbean heritage?

Qualitative explorations have found that Somali refugees in Sheffield reported that the extra problems faced such as unemployment, lack of health and social care systems, cultural and language barriers, and feelings of homesickness and statelessness made them susceptible to drugs (Nabuzoka and Badhadhe, 2000). This idea is furthered by Fountain (2009a) who found that Black African communities reported drug use as a means to 'forget about problems'. Although this is a common finding across ethnicities.

One particular factor discussed in the literature is peer pressure/influence and its particular power within minority groups (Bashford et al, 2003). This paper discusses the way in which a desire to be part of a wider culture, and to separate oneself from traditional values and/or older generations might exacerbate the effects of peer pressure within minority groups. Indeed, 36% of BAME participants reported that they took drugs due to peer influence (it is not possible to compare this to white groups as a direct comparison was not made in this study). The authors noted that this is not evidence of a specific motivational factor for BAME people and an American study found that Black adolescents were more resistant to peer pressure to take substances than white adolescents (Brown, Miller and Clayton 2004).

Other possible explanations are that BAME populations are more likely to be living in areas with greater economic and social deprivation where drug suppliers are rife and that this has an accumulative effect as the area becomes more impoverished as the area has a reputation for drug use (Bashford et al, 2003). This hypothesis is furthered by a qualitative investigation of drug workers: "...you end up with a lot of people being resettled into areas of urban poverty where substances are widely available." (Drugs worker and educator) (Cragg Ross Dawson, 2004).

What are the reasons for substance use in clinical populations of people of Black African and Caribbean heritage?

Inconclusive. There was a lack of data available to address this question.

Are reasons different between populations?

Inconclusive. There was a lack of data available to address this question.

What are the clinical conditions associated with substance use in people of Black African and Caribbean heritage?

The development of psychosis has been found to be particularly associated with high Tetrahydrocannabinol (THC) content cannabis, such as skunk, in a study based in South London, where there is a large Black African and Caribbean population (Di Forti et al, 2015). It was not possible in the timeframe to find further evidence addressing this question.

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What are the rates of substance use service uptake for people of Black African and Caribbean heritage?

Overall, about 3% of users of UK substance use services are from Black African, Caribbean or Black other ethnic groups, which is proportionate to their representation in the general population. There appear to be differences between Black ethnic groups with regard to take-up of substance use services. Black African service users seem to be under-represented in substance use services as they make up only 1% of clients despite Labour Force Survey (LFS) estimates suggesting that Black Africans made up nearly 2% of the UK population in 2016.

It seems that Black Caribbean service users are over-represented in non-opiate substance services, representing 3-4% of non-opiate only clients despite people identifying as Caribbean only equating to 1% of the English population as a whole (National Drug Treatment Monitoring System ((NDTMS)) 2016/17).

Ethnicity	Opiate	Non-opiate only	Non-opiate and alcohol	Alcohol only	Total
White British	85%	80%	83%	86%	85%
Caribbean	1%	3%	2%	1%	1%
African	0% (N = 414)	1%	1%	1%	1%
Other Black	1%	1%	1%	0%	1%

Table 4: NDTMS 2016/17 statistics on substance use service use by ethnicity

What are the ethnicity differences in drug-related prosecutions?

There is marked over-representation of Black people among those arrested (14% of those arrested for drug offences in 2007/08 were Black) and sentenced (22% of those sentenced for drug offences in 2007/08 were Black or Black British) for drug offences (Riley et al 2009).

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Ethnicity	Rate of drug offence arrests 2007/08	Proportion of those convicted for drug offences by ethnicity 2007/08
White	74%	11%
Black or Black British	14%	22%
Asian or Asian British	8%	18%
Chinese or Other	2%	28%

Table 5: Ministry of Justice data on rate of arrests and sentencing for drug offences by ethnicity as read in Beddoes et al (2010)

What are the potential explanations for the ethnicity differences?

Inconclusive. There was minimal evidence available to address this question.

Conclusion:

We were struck by the paucity of data regarding substance use in Black African and Caribbean communities, particularly given the high rates of arrests and convictions for drug offences and also, the frequent anecdotal reports of drug use in Black people entering the mental health system. In addition, it was striking that there is a marked discrepancy between access to substance use services and the rates of substance use in this group. There is a need for high quality data into substance use in Black populations as well as research into the types of interventions that might support people from Black African and Caribbean heritage who have co-occurring substance use and mental health problems.

5. Focus groups: a qualitative exploration of perspectives on the Mental Health Act and people of African and Caribbean descent

5.1 Background

People of African and Caribbean heritage are significantly more likely to be detained under the Mental Health Act (MHA) than members of any other main ethnic groups. Black⁶ service users' access to mental health services via adverse care pathways and inferior experiences of care have been reported for several decades, representing some the greatest and most intractable disparities in mental healthcare provision. However, the voices of African and Caribbean service users and carers in relation to detention under the MHA are seldom heard. Gaining insight into their experiences would facilitate understanding of present service challenges and help to identify opportunities for improvement. The Mental Health Act Review African and Caribbean group (MHARAC) therefore determined that it was vital to hear directly from these key stakeholders about their experiences and perceptions of the MHA.

5.2 Aims

- To improve understanding of the lived experiences of individuals directly affected by the MHA – specifically, those of Black African and Caribbean origin.
- To explore key stakeholders' (service users, carers and AMHPs) perspectives on use of the MHA within African and Caribbean communities.
- To identify changes with the potential to improve Black African and Caribbean service users' and their significant others' experiences of detention under the MHA.

⁶ 'Black' is capitalised to highlight that 'Blackness' is about more than skin colour, emphasising the racialised position of African descended people in contemporary society.

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5.3 Methods

Qualitative data were generated via focus groups comprising 45 key stakeholders: service users, carers and AMHPs. To enable maximum variation, focus groups were held in different geographical locations in the north, midlands and south of England.

The primary inclusion criteria for service users were i) self-identification as members of African and/or Caribbean communities, including those who self-identify as 'Black British' or 'Mixed' heritage and ii) lived experience of detention under the MHA.

Carers/family members did not have to be of African or Caribbean origin but must have had family members from these ethnic backgrounds who had been detained under the MHA. To enable exploration of perspectives on the MHA over time, no restriction was placed on when people had been detained.

Data collection was conducted using semi-structured interview schedules designed for the study. These were based on current literature and discussions with wider groups of ethnic minority service users, carers and advocates.

Data were analysed using Framework Analysis – an approach that enables both exploration of a priori themes and emergence of important issues a posteriori. To facilitate reporting here, findings are presented in relation to two key research questions that are aligned to the study's aims:

- What are Black (African and Caribbean descended) service users', carers' and family members' perceptions and experiences of the MHA?
- What modifications, if any, are needed to improve Black people's experience of being 'sectioned' under the MHA?

5.4 Key findings

Question 1: What are Black (African and Caribbean descended) service users', carers' and family members' perceptions and experiences of the MHA?

According to respondents, race-based discrimination is a defining feature both of Black people's experience of detention under the MHA and their everyday lives as exemplified by police involvement in their care pathways:

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'The police don't come to your house and knock on the door and say "look, I give you 5 minutes to open your door". The police come to me and say "if you don't open the door, we'll smash it in" (...) Why is it that Black people get treated in that kinda way?' (Service user, Manchester)

Participants reported that discriminatory practice at the hands of the police is reflected in their care and treatment by mental health staff, including: unnecessary use of force; unjustified suspicion; lack of effort to communicate; overuse of sectioning; more restrictive care; over-reliance on psychotropic medication (often forcibly administered); and lack of access to evidence based psychological care:

'When I was in [hospital] (...) there was all White people and they didn't approach me for, for weeks [original emphasis].' (Service user, Merseyside)

'... they don't tell you what's in that shot when they knock you out, ya know, the booster. I remember having 7 of them in one day.' (Service user, Manchester)

'The way that BAME men and women who have reached crisis point are treated is disrespectful, inhumane and inappropriate' (Carer, Bristol)

Participants also reported that mental health professionals' approach to their care suggested that they drew upon stereotypes Black men in particular, being "big, Black and dangerous" (Service user, Manchester).

'I had a young 15 year old Black Caribbean male, the first presentation (...) He had a section 2. Then he had a 3 and then (...) the next step "we'll consider a CTO". What for? What have you actually tried in the community? You haven't discharged him. You haven't even tried him on leave, escorted or unescorted leave. You haven't tried anything (...) You're just thinking of him as a scary Black guy who just you just need to control' (AMHP, London)

'It's a Black guy. He's young guy. I know he smokes weed. I know he's unwell. He needs to be detained' and that narrative doesn't change." (AMHP 2, Participant 1, London)

They also reported staff members' failure to protect them from racist abuse and mistreatment from both other members of staff and service users:

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*'(...) when I was in that (...) hospital there was there was a lad in the bed opposite me (...) he kept having this internal monologue with someone (...) going "yeah, and there's a fella over there who's a Black c*nt" (...) So I went to the staff (...) they said "ah well, you know it's his voices" and stuff like that (...)and then he's at it again' (Service user, Merseyside)*

In consequence, participants reported feeling unsafe in 'places of safety', including hospital wards:

'... they've took ya from your property (...) or from your family community to take you to a place of safety and (...) you can't get no sleep because you're scared of where you are and some of the patients they really, really mad! (...) You look at them. You see the real devil in them [laughter]. You're scared to fall asleep in case they do summat [something] to you. So this place of safety that they talk about is not always what it's cracked up to be.' (Service user, Manchester)

AMHPs pointed out that the law advocates using 'the least restrictive practice'. However, the general consensus was that there seems to be an unwritten norm of "restrictive practice as standard" (AMHP, London) for Black service users as exemplified by this quote:

"Look at any forensic ward. Look to see how many [Black] people are on there (...) they make them go onto Section 3 before they transfer them to forensic ward (...) full of young Black men. So, straight away you're going opposite to least restrictive practice (...) Section 2 as opposed to Section 3. So you're demonising these people by putting them on Section 3, putting them on forensic [units]." (AMHP – Group 2)

In comparison to their white counterparts, Black patients are disproportionately restricted in terms of: setting (ie hospital instead of community); physical restraint (ie section 136); and treatment orders (ie disproportionate use of CTOs).

'What they were saying is this was a violent, dangerous, woman (...) who needed to be in medium secure (...) I read her case from back to front (...) She was compliant with medication. No problems. No issues. No concerns. And they wanted to transfer her to medium secure.' (AMHP, London)

'if you understand about the research in regards to restraints and people dying in hospital through restraint (...) it's Black individuals predominantly (...) higher proportion that die through restraint than any other ethnic groups' (AMHP, London)

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'I go in voluntary and you can guarantee within 72 hours I'm on a Section 3 and I don't get no leave off the ward.' (Service user, Liverpool)

Question 2: What modifications, if any, are needed to improve Black people's experience of being 'sectioned' under the MHA?

From stakeholders' perspectives, service users and their families should be more involved in care and discharge planning:

'I think I was on compulsory treatment order or whatever, community treatment order (...) nobody discussed it with me. You don't discuss your care plan. They [family members] need to be more involved in our own care, which is just what the NICE guidelines say anyway but it's not happening. There should be a way to make sure something like that happens.' (Service user, Manchester)

'They say there's a care plan but, I remember (...) they sent me home (...) all I could feel like everything was just crowding in on me (...) I ended up at [hospital name] and they took me back for a night, but, planning, there's no such thing. They've got it down on paper but, in practice, I don't think they've got the time.' (Service user, Manchester)

Greater diversity in the workforce and improving the cultural awareness and competence of individuals involved in detaining service users from minority backgrounds was also regarded as essential and long overdue.

'All you need to do is look at all the psychologist (...) they're usually White. They're usually female. None of them, studied, ya know, transcultural therapy. So they don't know what you know and then they say (...) the person's not therapeutically minded' (AMHP 2, Participant 1, London)

Cultural competency should include improved understanding of factors that influence the onset, maintenance and recovery from mental ill health, focusing on empowerment and empathy. In this context, respondents suggested that training should explicitly address racism, discrimination and other determinants of mental ill health. Acknowledging the existence of cultural differences and ethnic discrimination within as well as between groups was regarded as integral, which some participants referred to 'hidden racism'. In their view, current approaches could worsen rather than improve Black service users' experiences as exemplified by this comment:

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'They don't realise that the Africans and Jamaicans, sometimes don't get on (...) and when you talk to them as a Jamaican and they might be from maybe, some part of Africa, they give you a hard time. Harder than the White man' (Service user, Manchester)

In this context, currently-available training was regarded as ineffective:

'They have it [the diversity training], but it's not working' (Carer, Smethwick)

5.5 Summary

From the perspectives of service users, carers and AMHPs, the MHA is used differentially in relation to Black service users of African and Caribbean backgrounds compared with their white counterparts.

In this regard, the vulnerability, racism, and fear experienced by service users in hospitals which are intended to be places of safety for those detained under the MHA warrants urgent attention.

Participants highlighted lack of compliance with the Human Rights Act 1998 and the Equality Act 2010 (specifically, the Public Sector Equality Duty) and application of the principle of least restrictive practice.

Over-reliance on medication, lack of access to psychological therapy, culturally insensitive care and overly discriminatory practice were perceived as extensions of the individual, societal, and institutional racisms experienced by Black service users and their families in everyday life.

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Annex 1: The Patient and Carer Race Equality Framework (PCREF)

The Patient and Carer Race Equality Framework (PCREF) will provide a methodology that supports the development of an organisational competence tool around race equality in mental health, designed to improve health outcomes, social outcomes and patient/carer experience and satisfaction for African and Caribbean people. This will include a standard of care that patients and carers should expect to receive, the organisational competences required to achieve this and a patient- and carer-rated tool for quality of care. The PCREF will provide information on what services should do to ensure that patient and carer race equality is achieved. The PCREF will fulfil the recommendation for a Patient and Carer Race Equality Standard⁷ set out in the [Old Problems, New Solutions report](#) (Crisp, Smith and Nicholson, 2016).

Background

The profound inequalities that exist for people from BAME communities in access to treatment, experiences of care and outcomes following care represent an overwhelming need for policy change to support effective local action:

- The consistent overrepresentation of Black African and Caribbean people in detention is symptomatic of systematic failures to respond to the needs of this community, and they have not been reduced by several recent policy initiatives (such as the [Delivering Race Equality programme](#) in 2010)
- People from Black African and Caribbean communities are 40% more likely than white British people to come into contact with mental health services through the criminal justice system, rather than referral from GPs or talking therapies
- Black adults are more likely than adults in other ethnic groups to have been detained under a section of the Mental Health Act
- White British adults are more likely to receive treatment for mental health problems than adults in other ethnic groups (13.3% for white British adults versus 6.3% for Black adults, who have the lowest treatment rate)

⁷ The term 'Patient and Carer Race Equality Framework' is used to more appropriately reflect the intentions of this work. This term replaces 'Patient and Carer Race Equality Standard' but will fulfil the same recommendation.

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People from BAME communities have an especially high risk of being sectioned, with Black African and Caribbean communities having poorer outcomes over time. The extent to which factors such as discrimination, poverty and social exclusion play a role in the over-representation of BAME people being detained under the Mental Health Act is unclear, despite the significant amount of research seeking to explain observed differences. Based on consultation and focus group research with participants from BAME communities, we have concluded that factors such as a lack of cultural awareness in staff and a need for culturally-appropriate care, as well as structural factors which engender racism, stigma, stereotyping and increase the risk of overmedication may play a role in the differential experiences of BAME communities.

Equality

The Equality Act 2010 protects people with protected characteristics against different forms of discrimination.⁸ These characteristics include disability (which can include any mental health condition, learning disability or autism), race and sex.⁹

Direct discrimination (s13) – occurs where an individual or organisation that provides services to the public (a “service provider”) or an organisation carrying out a public function (including private mental health providers) treats someone **worse** just because of one or more **protected characteristics**.

Indirect discrimination (s19) - indirect discrimination occurs when a practice policy or rule that applies in the same way to everybody disadvantages a group who share a particular protected characteristic. If this happens, the person or organisation applying the rule must show there is good reason for it. The Equality Act calls this ‘objective justification’¹⁰. An example of indirect discrimination might be where a GP practice has a rule that all patients must show proof of address when registering to join the practice. This applies to all new patients regardless of their protected characteristic, but Gypsies and Travellers, who are new to the area, are less likely to be able to provide a proof of address and therefore they will find it more difficult to register.

⁸ For further information, see EHRC introductory text here: <https://www.equalityhumanrights.com/en/equality-act/equality-act-2010>

⁹ The full list of characteristics protected by the Equality Act is age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, sexual orientation. For further information, please see here: <https://www.equalityhumanrights.com/en/equality-act/protected-characteristics>

¹⁰ For more information about objective justification see Chapter 5 of statutory Code of Practice here <https://www.equalityhumanrights.com/en/publication-download/services-public-functions-and-associations-statutory-code-practice>

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This could be **indirect discrimination** against Gypsies and Travellers because of the protected characteristic of **race**. The rule seems fair, but it has a worse effect on this particular group of people and could be unlawful unless the GP practice can justify it.

Unfavourable treatment arising in consequence of a disability (s15) - this occurs where someone is treated badly because of something related to their disability, such as having an assistance dog. This can also be objectively justified and does not apply unless the service provider or the organisation carrying out a public function knows the person has a disability or ought to have known.

The Equality Act sets out the **duty to make reasonable adjustments** for disabled people (s20). If a service provider or an organisation carrying out public functions finds there are barriers to disabled people in the way it does things, then it must make reasonable adjustments to eliminate them. The reasonable adjustment duty will be particularly relevant where people, for example in secure settings need additional steps to be taken to enable them to access facilities eg communication through an interpreter to access therapy.

The other Equality Act duty which applies to all public bodies (including NHS Commissioners and providers) listed in the Equality Act and to all organisations carrying out public functions is the **public sector equality duty (s149)**.¹¹ This duty is discharged by having “due regard” to the following three aims each time an option, policy or practice is introduced and each time its impact is assessed and reviewed:¹² **Where adverse impact is detected having considered these three aims, public bodies need to consider whether there are ways they could reasonably mitigate that impact.**

- The need to put an end to unlawful discrimination, harassment, victimisation or any other conduct prohibited by the Equality Act.
- **The need to advance equality of opportunity between people who share a protected characteristic and those who do not.** This will involve having “due regard”¹³ to the need to remove or minimise disadvantages suffered by people due to their protected characteristics, take steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people, and

¹¹ See EHRC introductory guidance here: <https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty>

¹² This is taken from the public sector equalities duty contained in s.149 Equality Act 2010; each of these three are objectives to which public authorities have to have regard to in specific contexts.

¹³ See EHRC guidance which states that “due regard” requires the relevant body to have made itself fully aware of and fully understand what the equality duty requires and this knowledge must have been put into practice.

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encourage people with certain protected characteristics to participate in activities where their participation is disproportionately low.

- The need to foster good relations between people who share a protected characteristic and those who do not. This includes tackling prejudice and promoting understanding between people from different groups.

The work MHARAC group has done particularly focuses on these three aims of the public sector duty of the Equality Act 2010. It is clear that given the ongoing disproportionately low rates of Black African and Caribbean people receiving mental health treatment in non-hospital and community settings; the low uptake of community mental health care; disproportionately high rates of detention and greater likelihood of detention in intensive care and secure settings, this group of people suffer ongoing disadvantage related to the protected characteristic of race. Public bodies need support to ensure they fulfil their public sector duties under the Equality Act 2010. The guidance provided thus far has been insufficient to do this.

The MHARAC group are proposing that public sector bodies develop an organisational competence framework aimed at supporting the delivery of race equality in mental health – the Patient and Carer Race Equality Framework (PCREF). The development of an organisational competence framework presents an opportunity to support organisations to operate differently in response to the particular needs of BAME communities, resulting in net cost savings to the system through a reduction in direct health sector costs; improvement in productivity (costs of absenteeism, unemployment, lower performance at work and so on) and reduction in intangible costs, such as pain, suffering and premature death (Elias and Paradies 2016).

Aims of the PCREF

- To ensure equality of treatment access, experiences and outcomes of mental health care regardless of race/ethnicity
- To provide a developmental competence framework for services that guides them towards a system which will provide equitable mental health care regardless of race/ethnicity
 - This will include domains and indicators that services will use to show they have achieved a level of high quality care (including evidence, patient and carer information, percentage of people accessing the service relative to the population, and so on)

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- To develop a patient and carer rated tool, which will be a measure of the experience of mental health services by BAME people. This will be embedded within the organizational competence framework and will be used to measure improvements over time specifically for those from BAME backgrounds.
- To provide a methodology for determining the percentage of people from a particular race or ethnicity that should be represented in services relative to the population
- The Crisp commission's [Old Problems, New Solutions report](#) (2016) made a recommendation to identify a clear and measurable set of Race Equality Standards for acute mental health services – the PCRES, which they suggested should be developed to test whether the WRES is having the desired effect of improving services.
- This was endorsed as part of the [FYFVMH](#) (2016), particularly in light of persistent inequalities in early intervention and crisis care, rates of detention and lengths of stay in secure services since the end of the five-year DRE programme (2010).
- In 2014, the Joint Commissioning Panel for Mental Health (2014) issued guidance around the commissioning of mental health services for BAME people. This guidance drew on the findings and recommendations from the DRE and attempted to outline what good mental health services for BAME people should look like. In response to the DRE and other guidance, some areas developed initiatives aimed at improving outcomes for BAME groups, however, these projects have not been sustained or were side-tracked, with BAME issues no longer being the main focus of their work eg The Revolving Door Project in Birmingham and Solihull Mental Health Foundation Trust, Community Development Workers.
- The DRE was successful in raising awareness of race inequality issues in mental health and in encouraging the development of initiatives to support equality of access and outcome, however these initiatives have not generally been embedded in mainstream services. Over the years there has been insufficient improvement in outcomes for BAME people particularly with respect to detention under the Mental Health Act.
- A different approach to supporting the delivery of more equitable mental health services is required, with more fundamental change in the way that services are organised is required.
- Building on the aims and recommendations of the Crisp Commission, the FYFVMH, the DRE, Guidance from the Joint Commissioning Panel for Mental Health and the WRES, we propose the development of an organisational competence framework, aimed at iteratively developing and embedding practices which will enhance race equality in mental health into the fabric and structure of services and in this way

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improve the quality of services and the experience of BAME people who come into contact with those services. This will be the Patient and Carer Race Equality Framework (PCREF).

- As with the Workforce Race Equality Standard (WRES), the aim of the PCREF is to improve race equality by improving the experience and outcomes for people from BAME backgrounds. The PCREF builds on the work that has been done previously. It is not simply a standardising and benchmarking system. It introduces a competence framework that will deliver an incremental developmental approach to reducing race inequalities in mental health. It will incorporate clear guidance that allows local solutions for local population needs, which if followed will result in systemic change that will result in better outcomes and experience for BAME people in contact with mental health services.

The Organisational Competence Framework

- The Patient and Carer Race Equality Framework (PCREF) will be an organisational competence framework that supports the recommendation for a Patient and Carer Race Equality Standard (PCRES).
- Work led by the Mental Health Act Review African and Caribbean Working Group (MHARAC) of the Independent Review of the Mental Health Act has focused on methods for addressing systemic injustices in relation to the experiences of people of African and Caribbean descent who receive treatment under the Mental Health Act.
- There is wide-ranging support for a framework to hold local systems to account more robustly, to improve overall outcomes for Black people, bringing the perspective of patients and carers to the centre of service-led quality improvement agendas – directly correlated to the aims of the PCRES.
- The PCREF has the potential to lead to an enhancement of relationships between services and communities, enabling services to re-align structural processes such that they are better able to achieve equity of outcomes for Black people and indeed those from other ethnic minority communities and thus over time, build confidence that they can adequately respond to the needs of African and Caribbean people in the right way at the right time. This should encourage people with mental health needs to present earlier and avert crisis. There are then likely to be fewer admissions and detentions under the Mental Health Act, particularly for people from African and Caribbean communities. This will bring clinical, social and economic benefits in both the short and long term.

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What is it?

- The PCREF is a **practical methodology that supports services to improve by helping organisations to understand how to improve and incentivises and measures attainment against set levels of service.**
- The PCREF is practical and aids the delivery of improved care using a **quality improvement approach** that is tailored to each local area.
- It is important to note that the PCREF will **support organisations to fulfil largely existing obligations under the Equality Act** (such as their [Public Sector Equality Duty](#)) and to collect and use data efficiently and effectively.
- Equally important is that the experience of the PCREF can be exploited beyond the health system. A similar approach can be used by other public sector bodies to support their obligations under the Equality Act 2010 – something particularly relevant to the crossover with, for example, the criminal justice system in relation to the Mental Health Act.
- Development of the PCREF will include an appraisal of those aspects of mental health services which are most relevant to African and Caribbean people, using existing data and taking into account feedback from engagement with relevant service user groups and stakeholder organisations.
- In addition, a patient and carer rated experience tool should be developed as part of the PCREF which will form one of the main methods of measuring improvement and quality in services.
- An outline of an example organisational competence framework is below. It shows how a provider or commissioner of services can develop their offer over time to enhance the mental health care delivered to people from BAME backgrounds. It is expected that this would be done in an incremental way that follows an iterative process, allowing cultural change to be embedded into the mental healthcare delivery system. An incentive for change in the example is the use of additional funding, but different drivers and levers could be utilised to facilitate implementation of the PCREF, eg showcasing and publication of those services which fulfil Level 1 criteria.

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How will it work?

- An example organisational competence framework based on financial incentive is outlined below. Organisational competence frameworks could be developed using a sanction approach rather than an incentive approach or a chartermark approach, with better services being awarded a chartermark for race equality. This information would be in the public domain and could be used by the local community to determine the quality of their local services. In the example in the appendix;
 - **Levels** of attainment contain **goals** that organisations can achieve, underpinning the duties of the Equality Act.
 - The **goals** focus on awareness, staff capability and training, data and monitoring, and service development and any other factors deemed to be critical in delivering cultural and structural change.
- Service providers will be mandated to develop and/or comply with a pre-developed framework, most likely via the Equality Act. They will be required to set out their plans for achieving Level 1 status with timelines. These will be subject to review by a regulatory/oversight/contracting body.
- Each trust can work towards the goals by **responding to the needs of their individual population**, taking decisions on a local level about required actions.
 - A sum of money may be made available for areas to bid for, to support the development of, for example, substance misuse services that support the achievement of set goals.
- It is expected that there will be a role for the Care Quality Commission (CQC) and/or other equivalent regulatory bodies to **monitor compliance and attainment on a national level**, with patient and carer representatives having an active role in the assessment.
 - This may require additional powers (and resource) to enable the CQC to pay attention to individual cases and undertake appropriate sanctions (possibly at individual ward level).
- A system of incentives, levers and drivers should be developed with relevant Arms Length Bodies, such as NHSE or the Local Government Association and other stakeholders to facilitate adherence to and delivery of the PCREF.

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An example of an Organisational Competence Framework for race equality in mental health care

An example of what a level-approach competence framework could look like. The example includes 5 levels that could be achieved, each of which has different funding incentives. The actual framework would be developed comprehensively, with engagement and consultation with relevant stakeholders. This is intended to provide an example only.

(Note: this version uses additional funding as a lever for change. Evidence of each criteria should be provided)

Level 1. Full funding, renewed annually for three years then renewed triennially

- Evidence of **specific activities/processes** aimed at improving the mental health of people from BAME backgrounds. Such evidence includes:
 - Interfaces with other agencies to support and manage the mental health of people from BAME backgrounds, including third sector and primary care
 - Following agreed protocols with external agencies such as primary care, detailing the action to be taken and referral paths to be followed (including abnormal results from physical investigations)
 - Evidence of co-produced, culturally-appropriate services
 - Substance-use services that cater for the needs of people from BAME backgrounds
 - Evidence that culturally-appropriate mental health interventions are being developed and used
 - Providing a physical health screen clinic that can be accessed by all people from BAME backgrounds who have a mental health diagnosis
 - Running a healthy lifestyle intervention programme that includes individual as well as group activities
- Evidence of **awareness of mental health issues** in people from BAME backgrounds:
 - Board adopt this as a quality priority and there is evidence of regular oversight of services delivered to people from BAME backgrounds, their access to these services and outcomes in this group

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- Board has a responsible officer who oversees matters for different BAME communities
- Evidence that training into **the understanding of implicit/unconscious bias as well as equality and diversity training** is mandatory:
 - 75% of staff are trained
- Evidence of **routine collection and monitoring of race, ethnicity and other equalities data** in local population demographics, service provision and delivery:
 - Maintaining a register of people receiving care by demographic (including ethnicity/race) and transparent information on how this data is used to improve delivery of care
 - Recording physical health screening data for people from BAME backgrounds
- Evidence that a specific process is followed to ensure all people from BAME communities are **registered with a GP**
- Consistently good or above rating on the Patient and Carer experience measure

Level 2. Eligible for funding to support service improvement to enhance equality outcomes

- Evidence of **specific activities/processes** aimed at improving the mental health of people from BAME backgrounds, such as:
 - Interfaces with other agencies to support and manage people from BAME backgrounds, including third sector and primary care
 - Following agreed protocols with external agencies such as primary care, detailing the action to be taken and referral paths to be followed (including abnormal results from physical investigations)
 - Evidence of co-produced, culturally-appropriate services
 - Substance-use services that cater for the needs of people from different BAME backgrounds
 - Evidence that culturally-appropriate mental health interventions are being developed and used

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- Evidence of **awareness of mental health issues** in people from BAME communities:
 - Board adopts this as a quality priority and there is evidence of regular oversight of services delivered to people from BAME backgrounds, their access to these services and outcomes in this group
 - Board has a responsible officer who oversees matters for people from BAME backgrounds
- Evidence that training into **the understanding of implicit/unconscious bias as well as equality and diversity training** is mandatory:
 - 75% of staff are trained
- Evidence of **routine collection and monitoring of race and ethnicity and other equalities data** in local population demographics, service provision and delivery:
 - Maintaining a register of people from BAME backgrounds
 - Recording physical health screening data for people from BAME backgrounds
- Evidence that a specific process is followed to ensure all people from BAME backgrounds are **registered with a GP**.
- Consistently **good or above** rating on the Patient and Carer experience measure

Level 3. Eligible for limited funding to support service improvement to enhance equality outcomes

- Evidence of **specific activities/processes** aimed at improving the mental health of people from different BAME backgrounds. Such evidence includes:
 - Interfaces with other agencies to support and manage people from BAME backgrounds
 - Evidence of co-produced, culturally-appropriate services
 - Substance-use services which cater for the needs of people from different BAME backgrounds
- Evidence of **awareness of the mental health issues** in people from BAME backgrounds:

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- Board adopts this as a quality priority and there is evidence of regular oversight of services delivered to people from BAME backgrounds, their access to these services and outcomes in this group
- Board has a responsible officer who oversees matters for BAME people
- Evidence that training into the **understanding of implicit/unconscious bias, as well as equality and diversity training**, is mandatory:
 - 50% of staff are trained
- Evidence of **routine collection and monitoring of race and ethnicity and other equalities data** in local population demographics, service provision and delivery:
 - Maintaining a register of people from BAME backgrounds
 - Recording physical health screening data for people from BAME backgrounds
- Evidence that a specific process is followed to ensure all people from BAME backgrounds are **registered with a GP**
- Satisfactory rating on the Patient and Carer experience measure

Level 4. Start of eligibility for funding of service improvement to enhance equality outcomes

- Evidence of **awareness of the mental health issues** in people from BAME backgrounds, such as a position statement, mission statement or board-level report
- Evidence that the organisation runs **training for staff in culturally competent practice**:
 - Evidence that **equality and diversity training** is mandatory requirement for all staff (managerial, administrative and support as well as clinical staff)
- Evidence that training into the **understanding of implicit/unconscious bias as well as equality and diversity training** is mandatory
- Evidence of **routine collection monitoring of race and ethnicity and other equalities data** with respect to local population demographics and service provision and delivery.
- Provides routine culturally-appropriate mental health interventions

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- Uses patient and carer experience measure to specifically measure quality of care for BAME people.

Level 5. Not eligible for funding

- No evidence of awareness of the mental health issues in people from BAME backgrounds
- No evidence that staff are trained in culturally competent practice.
- No evidence of training into the understanding of implicit/unconscious bias.
- Provides no routine monitoring of race and ethnicity data in local population demographics, service provision and delivery.
- Provides no routine culturally-appropriate mental health interventions
- No routine measurement of quality of care or experience for BAME people receiving mental health service.

Annex 2: Substance misuse and use of the Mental Health Act

'During the 11 years 2004/05 – 2014/15, 82% of people who died in or following police custody had some link to alcohol and/or drugs. Overall, 49% of those who died had alcohol and/or drug related factors identified specifically as a cause of death in a post-mortem examination.' (1)

Report of the Independent Review of Deaths and Serious Incidents in Police Custody (Dame Elish Angiolini, 2017).

Alcohol, drugs and mental illness is a major health concern which we believe has received insufficient attention with regard to the use of the Mental Health Act. Despite the importance of co-occurring alcohol, drugs and mental illness it is difficult to find data that relates to the above issue, as the Mental Health Minimum Data set does not record substance misuse use data in any useable form; indeed such data is often not recorded at all.

Within adult mental health treatment populations Weaver et al found that 44% of the community mental health team sample had a substance misuse problem in the past year (3).

Studies conducted in the UK, France and Germany found that 35% of the UK schizophrenia cohort had co-occurring drug or alcohol dependence, much greater than the levels seen in the other countries (4). Those who were dependent were more likely to be younger men, with shorter clinical histories of psychosis, with more severe symptoms, but fewer negative symptoms such as lack of motivation and emotional flattening. They had poorer functioning on psychosocial and quality of life scales. Standardised mortality rates (SMR) refer to the number of observed deaths in a group compared with the expected deaths in the general population. The SMR of patients with schizophrenia as a result of substance misuse related issues in the Welsh population was found to be 8.2, indicating that these people are eight times more likely to die than the general population (5). Equivalent data was not available for England.

Unsurprisingly, given the high rates of both historical and current substance misuse in incarcerated populations, levels of co-occurrence are high. One study of the English prison system suggested that 78% of those in six English prisons with a severe mental illness (defined as a current episode of major depressive disorder, bipolar disorder or any form of psychosis), had a substance misuse issue (6).

Early data from police liaison and diversion schemes for mental health suggested that the 55% of service users with mental health issues who had contact with these schemes also had problematic drug and/or alcohol use (7).

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A large cohort study carried out in England suggested that the SMR of an opioid dependent individual by suicide was 4.5 (8). One study in a South London opioid dependent population revealed comorbid opioid and personality disorder was associated with increased mortality when compared to opioid dependence on its own (9).

More than half psychiatric patient suicides are in those thought to have co-occurring alcohol or drug problems (10).

In 2017 Prisons and Probation Ombudsman Nigel Newcomen stated to the House of Lords:

'As well as mental ill-health, another contributory factor to the increase in suicide in prison is the epidemic of new psychoactive substances. My researchers have now identified 79 deaths between June 2013 and September 2016 where the deceased was known or strongly suspected to have taken [new psychoactive substances] NPS before death or where their NPS use was a key issue during their time in prison. Of these investigations, 56 were self-inflicted deaths.(11).

Alcohol and drug use and dependence on such substances plays a major role in both acute psychiatric presentations and enduring psychological/psychiatric ill health. It is important to separate the psychological consequences of acute intoxication and withdrawal from those of substance dependence.

Para 3.1.2: 'On frequent occasions CC told doctors, nurses and social workers that he had abused both hard and soft drugs from an early age...from investigations we have been able to carry out none of these statements appear to have been true. Indeed there has never been any evidence that he abused drugs, save for his own assertions which then assumed a truth of their own as this statement was repeated from one hospital to another'

Para 4.8.1: '...Above all the opportunity for early diagnosis and possibly effective treatment of schizophrenia was lost'(2).

Acute intoxication and withdrawal

Anyone who uses substances is at risk of acute psychological events that could lead to assessment and detention under the mental health act. It is important to separate this from dependence. Stimulant drugs such as cocaine (powder or crack), and amphetamines, or cannabinoids can cause acute psychosis which warrants intervention from mental health services and others; GABA agonists such as alcohol, GBL and Benzodiazepines may

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cause psychosis in withdrawal. Most substances in either intoxication or withdrawal will place the user at risk of suicidal thoughts. About 1/3 of general population suicide in London involve significant levels of alcohol (Mike Kelleher, in progress). This is similar to levels found in the United States (12). Once substance effects subside often the psychiatric symptoms remit. This does not mean they do not need assessment and intervention by psychiatric services in the moment of crisis; even if they sober up the next day and regret the events of the previous evening.

What about withdrawal states?

Exclusion and unmet need

The recent Public Health England publication, *Better care for people with co-occurring mental health and alcohol/drug use conditions* (7), sought the views of service users. It suggested that there is significant unmet need in this group and that drug and alcohol use can be used as a means of exclusion in mental health treatment services and mental illness used as a means of exclusion in addiction services. It further notes that the Home Affairs Select Committee report on mental health and policing found that those in a crisis could be withheld vital support because alcohol or drug use was applied as exclusion criteria. The Making Every Adult Matter (MEAM) coalition noted that addictions and mental health services amongst others often failed to work collaboratively on the most to complex patients. It noted that patients with anxiety disorders with a history of drug or alcohol dependence could be excluded from some IAPT services. In practical terms large amount of time can be spent trying to decide primacy; to elicit whether the mental illness predated the addiction or vice versa. This can consume services and waste resource while time is spent trying to unpick this question. A question which may have no meaningful or relevant answer. More importantly it can serve to disillusion the patient about the availability and effectiveness of treatment and the friendliness of services. The service user often consigned to seek treatment elsewhere in an unevidenced and widely derided sequential model of care.

Aetiology of co-occurrence

There are many theories for why co-occurrence is so common including:

- That the substance use disorder and psychiatric illness share a common root, be it social adversity in childhood, genetic or psychological vulnerability.
- That those who develop a substance use disorder are as a consequence biologically at risk of a mental illness, or suffer social and psychological adverse events due to the substance use that cause a psychiatric illness

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- That those with psychiatric illness turn to substances to alleviate negative mood states and reduce anxiety; in essence a form of self-medication. This is made worse by the greater availability of alcohol and drugs in modern societies.
- That those who are socially isolated and stigmatized due to their mental illness engage in substance using networks due to such groups inclusivity.

The causes of co-occurrence are complex and multifactorial. It is important to understand both the external societal drivers of such conditions as well as internal psychological and biological factors. For example, it is notable that the EuroSc study found that in the cohort with schizophrenia the rates of co-occurring substance dependence were much lower in France (19%) and Germany (21%) than the UK (35%) even though rates of schizophrenia were similar(4).

Potential options for the MHA Review regarding this issue:

Implementing existing guidance on this issue including:

- NICE Guideline NG58: Coexisting severe mental illness and substance misuse: community health and social care services(13)
- From Public Health England (PHE): Better care for people with co-occurring mental health and alcohol/drug use conditions (produced as part of the FYFVMH) (7)
- From NHS England Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care (14)
- IAPT positive practice guide for working with people who use drugs and alcohol (15)

Supporting NHS Digital and PHE in ensuring data around drug and alcohol use is recorded for all new patient episodes including assessments under the MHA (process currently underway)

- Population-based measures and upstream interventions
 - Reduce availability of alcohol through licensing restrictions and minimum unit price
 - Stop the reduction in funding in addiction services and perhaps restore to previous levels.
 - Examine IAPT's exclusion of those that use or have recently used substances. Either implement the IAPT positive practice guide for working with people who use

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drugs and alcohol or give resource to addiction services to treat psychological conditions.

- Implement principles in above guidance of 'no wrong door' and 'everybody's job' and ensure that services work collaboratively together within guidance.
- Crisis interventions
 - Ensure patients are not turned away from services in a psychotic or suicidal crisis because it is perceived by professionals as substance induced
 - Ensure staff healthcare and police are aware of effects of substances and how they may present.
 - Trial nearside testing for substances in 136 suites through dignified testing (sweat, saliva rather than urine) which may direct intervention
 - Meaningful activity on closed environments (be it a psychiatric ward or prison)
 - Provision of harm reduction measures
- Post crisis interventions
 - Ongoing substance use is supported by boredom, lack of meaningful activity and isolation from social networks. Recreating activities and functioning networks through social interventions is vital
 - Ensure individual and wider community is aware of the effects substances have on their psychological health and the individual's responsibility for their use. Taking an information giving approach about the potential harms of substance misuse and substances effects on psychological health can allow them to make an informed choice about their use and some patients may be able to self-limit their use.
 - Ensure mental health services are able to address as much as possible drug and alcohol issues in line with NICE Guideline NG58
 - They are engaged with minimal barriers in their appropriate post hospital service- ('no wrong door' and 'everybody's job').
 - In those that choose to continue to use, moving away from an abstinence focused position (if the patient is unable or unwilling to achieve abstinence) and moving towards a harm minimisation one). This may involve tolerance of ongoing chaotic substance use. This may involve repeated admissions

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- Having consistent staff members that recognize that the patient may have had previous negative experiences in services that make them wary. Staff members need to avoid therapeutic nihilism with this group and recognises that quick fixes after brief episodes of treatment are often unsuccessful.
- Certain groups may avoid contact with services if they feel coerced or fear involvement with other agencies such as local authority child protection agencies. Another group that may struggle include the victims of intimate partner violence. Services should endeavour to adapt to make them as welcoming and supportive as possible to this group, at the same time being aware of their statutory responsibilities.
- The homeless have very high rates of co-occurring mental illness and addiction and mental health service provision should endeavour to adapt to their needs.
- Specialist dual diagnosis teams. NICE guideline NG58 notes that there is little evidence for specialist dual diagnosis teams. They state that this does not mean there should not be specialist dual diagnosis practitioners who can take on an advocacy and training role for those with co-occurring conditions; however, both pieces of guidance suggest that conditions are so common that all staff and services need to be competent to respond to issues, rather than seeking a container to place their most complex, stigmatised and disadvantaged patients.

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Annex 3: Evaluation of feedback from community engagement session regarding MHARAC recommendations

What is your overall assessment of the package of recommendations?

Question	Excellent	Very Good	Good	Satisfactory	Inadequate	Abstained
What is your overall assessment of the package of recommendations?	41%	38%	0%	10%	0%	10%

79% of respondents rated the MHARAC package of recommendations as Excellent or Very Good

Further comments or suggestions in relation to Excellent/Very Good:

- 'Specific targeting of BAME young people to actively encourage vocations in psychology.'
- 'Funds to support BAME psychology trainees in unpaid positions.'
- 'Resources in diverse areas to support BAME communities by providing specialist mental health support.'
- 'Are there any representation on MHARAC for education of prisons.'
- 'Huge amount of work done- and more to do. Engaging senior staff in organisations will be essential to move things at speed.'
- 'Thank you for doing this. I believe what Dr. Smith stated "we have to make it happen".'

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Further comments or suggestions in relation to ‘Satisfactory’:

- ‘This is just a brief start...’
- ‘Need to challenge.’

Do you think the Organisational Competence Framework will make a difference?

	YES	NO	ABSTAINED
Do you think the Organisational Competence Framework will make a difference?’	76%	6%	18%

Comments in relation to ‘Yes’:

- ‘Because it will greatly improve health of BAME...and in turn help the MHA to become more inclusive and holistic.’
- ‘This is the most focused approach I am aware of to date...’
- ‘It will encourage services to actively address inequalities.’
- ‘It fits well with current commissioning and contracting frameworks...however we will need a list of preferred providers of training.’
- ‘The recommendations are good but it’s concerning that they could be rejected by the government.’

Comments in relation to ‘No’:

- Referred to the 1959 MHA
- ‘Organisations are embedded in how they react...needs more than lip service.’

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Comments by those who abstained:

- 'I hope so.'
- 'Not sure, I think it will only work if it sits in a broader strategy for race equality.'
- 'Hopefully...my concern is how well it is developed (refers to importance of experience).'
- 'Depends on the...link between outcome and impact analysis.'

Would you be willing to work with your local mental health trust to develop services?

	YES	NO	ABSTAINED
Would you be willing to work with your local mental health trust to develop services?'	90%	6%	4%

Comments in relation to 'Yes':

- 'It is important to have accurate research data that addresses local community needs...'

Comments in relation to 'No':

- 'I think my current job role will see me working with local mental health trusts.'
- 'To design/structure/contribute towards accountability/transparency of institutional process'

Comments by those who abstained:

- 'It is not that I am not willing to work with local mental health trusts...the trust needs to work closer to the Black community.'

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Do you think the culturally-appropriate advocacy will make a difference?

	YES	NO	ABSTAINED
Do you think the culturally-appropriate advocacy will make a difference?	86%	6%	8%

Comments in relation to 'Yes':

- 'The chance for those to interact with someone who gets it and has scope and understanding.'
- 'From where will the advocates be drawn and are these to be paid or unpaid positions?'
- 'Yes yes yes. At the moment there is no one specific supporting cultural advocacy.'
- 'Advocacy provision is vital and must be available to everyone - cultural appropriateness makes this more likely.'
- 'Because it addresses long term neglect of sections of our community.'
- 'New models of psychology need to be introduced. CBT does not fit at all.'

Comments in relation to 'No':

- 'If used (post?) assessment. Patient management and discharge.'
- 'It's subjective. When I had issues I ended up seeing a lady who looked like my mum. I found it difficult to be open and worried she would judge. Later I saw a white lady. I was fine- I think choice should be available.'

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Comments by those who abstained:

- 'Hopefully.'

What, if any, of the recommendations will be most effective in improving outcomes for BAME people?

Comments

- 'All this has the potential to be ground-breaking, the difficulty you may face is how you manage the inevitable resistance to change. With buy-in this will succeed.'
- 'Consult more and implement (their?) reasonable recommendations.'
- 'All of them.'
- 'We need a national strategy for race equality across all sectors.'
- 'Receiving MH treatment at the right time in a culturally-appropriate matter.'
- 'Using good quality data to inform service developments and measure improvements or failures.'
- 'The ability to challenge your care and treatment and to be part of your own care.'
- 'Competence framework sounds good because it's willing to be subjective.'
- 'Impossible to say as too little information in all the recommendations.'
- 'Compulsory data collection'
- 'Discuss impact of treatment'
- 'Patient input into their care/treatment plan.'

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Topic Groups: Terms of reference and Reports

Status of the Topic Group Reports

Following the [interim report](#) of the Independent Review of the Mental Health Act 1983, the Review established a number of 'Topic Groups' to provide advice to the Review leadership on the following issues:

- Addressing rising detention dates - What interventions could reduce use of the MHA and compulsory admissions?
- Maximising autonomy: consent to treatment (Advance Decisions)
- Detention criteria
- Patient dignity and safety
- Advocacy
- Tribunals, hospital managers, renewals
- Family and carer involvement
- Community Treatment Orders
- Discharge, care planning and s117 aftercare
- Asian and minority ethnicities
- Children and young people
- Learning disability and autism
- Interface with Mental Capacity Act
- The police role
- Criminal justice system
- Principles underpinning the Act

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These groups operated over the summer of 2018, and submitted their reports to the Review leadership in September 2018. The terms of reference of these groups, and their final reports, are contained in this document.

These reports are working documents from the chair of the relevant topic group to the leadership of the Review. They do not represent final views or recommendations of the Independent Review of the Mental Health Act 1983. These are available in the Review's final report: [Modernising the Mental Health Act: increasing choice, reducing compulsion](#)'.

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Addressing rising detention rates - what interventions could reduce use of the MHA and compulsory admissions?

Chair: Sean Duggan

Working Group Lead: Viral Kantaria, NHSE

Secretariat: Esther Horner, DHSC

Membership

- Prof Michael Coffey - Swansea University
- Gail Dearing - East London NHS Trust
- Laura Giles on behalf of Alison Lowe – Touchstone
- Dorothy Gould - NSUN
- Julie Hankin – Executive Medical Director, Nottinghamshire Healthcare NHS Foundation Trust
- Emad Lilo - Social Care Professional Lead at MCNHSFT and Vice Chair AMHP Leads Network
- Craig Morgan - Kings College London
- Roger Talbot - MHA Service User and Carer Group

In addition to the core members, the topic group may bring in expert contributors for specific issues within the topic, or to test emerging findings.

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Terms of reference

Remit

As set out in the Interim Report, the topic group 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

The group will consider how current inequalities can be addressed in relation to the Mental Health Act, and any recommendations will consider the potential impact upon individuals identifying with protected characteristics under the Equality Act 2010. In particular, the review is seeking to address racial disparities, with a specific emphasis on people of African and Caribbean descent or heritage.

The purpose of this group is to identify potential recommendations the review could make, in relation to the above and to support the review's overarching goals (see below).

This is a complex and wide-ranging topic area, nothing is ruled out at this stage. The 'interventions' referred to above may not just be limited to secondary care mental health services, but also primary care, other public services, and community and social services/groups/networks.

To explore:

- Data analysis comparing detention rates over time broken down by mental health provider to determine provider geographies which appear to have bucked the rising trend
- Hierarchies of evidence (formal evidence, local reports, anecdote) – from evidence review and elsewhere

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- To use MH provider networks and AMHP networks to acquire any locality-based reports containing data and evidence
- Any relevant international data and/or evidence

Timing and outputs

i. Review point:

- Gap analysis and any additional research requirements by end of June.
- Progress update to the review by 20th July 2018.

ii. Final report

The group will produce a short report to the review leadership by 14th September 2018, using the agreed format, setting out key findings for consideration by the Review as they prepare their final report and recommendations to government.

The topic group's work will be supplemented by additional engagement activity.

Interdependencies

- Understanding why rates of detention under the MHA have increased
- Discharge, care planning and aftercare
- Maximising autonomy
- Detention Criteria
- The police role
- Family/ carer involvement

Review goals

- 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

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- 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

Report

1. Issue

Understanding the reasons for rising detention rates is one of the core aims of the MHA review. As set out in the interim report, the review's work to date has identified that 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 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.'

The understanding rising rates of detention expert topic group, working with the Policy Research Unit, continues to examine the perception and evidence of why rates of detention under the MHA have increased. In parallel, the addressing rising detention rates topic group has been looking at what interventions could reduce use of the MHA and compulsory admissions.

All topic groups have been considering the impact of their recommendations on the rates of detention. Whilst other topic groups are predominantly looking at procedures and processes once someone is in contact with the MHA, this topic group has taken a wider view, looking at the mental health system, the health and social care system and wider socio-economic factors, when considering options to tackle rising rates of detention.

2. Findings

In the way there is no single driver for the rising rates of detention, there are no simple solutions to addressing it. Tackling rising rates will require a long-term, well resourced, cross-government and multi-agency approach, which involves partnership working with user-led organisations, local community groups and groups initiated by people who experience marginalisation. The topic group has identified five recommendations for the review to make to government, as an important starting point.

Recommendation 1: Systematic data collection, routine national reporting and routine analyses across health, local authority AMHP services and policing needs to be improved as a matter of urgency by the DHSC, NHS England, NHS Wales, NHS Improvement, NHS Digital, the Care Quality Commission (CQC), Healthcare Inspectorate Wales, the Home Office, the Local Government Association (LGA) and the National Police Chief's Council (NPCC). From 2019/20, NHS England and its national partners (eg CQC, NHS Confederation) should establish an intelligence-led national support programme for the MHA to help Sustainability and Transformation Partnerships (STPs), Integrated Care Systems (ICS) and Health Boards in Wales, to understand and benchmark their local data, participate in new and draw on existing informal and formal research, and to encourage STPs and ICSs to take a leadership role in addressing detention rates in the context of their wider plans to improve mental health services.

Recommendation 2: Research and Evaluation – beginning scoping in 2019/20, the government and national arm's length bodies (ALBs) should work with national bodies such as the National Institute Health Research, Mental Health Policy Research Unit, user-led bodies, charities, regional research bodies such as Academic Health Science Networks and Collaborations for Leadership in Applied Health Research, and local systems including the NHS, local authorities and police forces, to fund and undertake a new major programme of research into service models and clinical/social interventions and their relationships to rates of detention. This research should include user-led studies and studies which focus on resources which mental health service users have said they find therapeutic.

Recommendation 3: Alternatives to detention and interventions to prevent crisis or the escalation of crisis should be made available. There should be a varied offer and funding of this provision, which will require a considerable change in culture and a reconsideration of what services receive funding. To achieve this, new suitably funded policy developments in England and Wales to improve community services need to be implemented.

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Recommendation 4: There needs to be a concerted, cross-organisation, drive to tackle the culture of risk aversion. This will need to include the Chief Coroner, CQC, NHSE, NHSI and trust boards, to understand the drivers of the current culture and how their functions and risk management can be improved to tackle this.

Recommendation 5: There is a need for an accompanying public awareness strategy, in line with the prevention concordat, which promotes community wide mental health and wellbeing promotion, including knowing how to respond to Mental Health crisis and what services are available.

3. Rationale

Assessing and detaining someone under the MHA is expensive, in both human and financial terms. In human terms, being assessed and detained can have a hugely detrimental effect on people's lives. It disconnects people from their relationships, their communities and their occupations leading to strain in the social fabric and creating distance between service users and their supports. It is not something to be done lightly or that should be driven by concerns that centre on blame or risk. This is for both the individual concerned as well as any family members or carers, who experience distress and worry.

In financial terms, assessment and detention can involve police time (section 136 or otherwise), section 12 doctor remuneration per assessment, AMHP time, transportation, the costs associated with an inpatient stay (given that people detained in hospital tend to stay for longer than 'informal' inpatients), the costs of advocacy, and the costs associated with section 117 aftercare for people discharged from a section 3.

We must establish a more proactive system of responsive, flexible community-based care to prevent crises escalating, including resources from user-led organisations, local community groups and groups initiated by people who experience marginalisation. We must also support people, and their carers, post-discharge from acute inpatient care or intensive home treatment, so they do not face a cliff-edge of lost care, which can trigger another crisis. These actions will save money, save distress, and, ultimately, save lives.

Over the last 20 years there has been a significant shift in view around the model and the philosophy of psychiatry. We have seen a greater focus on the social aspects that aid individuals in reaching their vision of individualised recovery. However, we are only on the cusp of this new approach, and this needs to be supported to develop to scale.

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Whilst not a universally held view, broadly there is agreement that there remains a need for the MHA¹⁴ to provide a legal framework to protect service users and professionals. However, there should be an increased focus on interventions to prevent crisis, and alternatives to admission and detention, when people do reach crisis point. The topic group's recommendations, set out in more detail below, are critical to ensuring that the system going forward is evidence based, takes a broad view of mental health and distress, is person centred and takes better account of individual's needs and wishes. The topic group is keen to emphasise the importance of taking a very broad and open-minded approach when considering services and provision which can benefit people in mental distress or crisis.

Systematic data collection

The topic group, and the review as a whole, has been hampered by the availability of good quality data, in order to understand the practices around the current MHA. A much more systematic data collection, across the mental health system, is urgently needed to help us better understand rising rates of detention, variations in detention rates across the country and disparities between different groups.

Whilst the review has specifically been asked to look at the disparities around detention rates amongst BAME communities, the topic group is also keen to ensure that other disadvantaged groups are also highlighted, and that a concerted effort is made to ensure that a systematic data collection aims to build a better picture of how all disadvantaged groups experience the MHA. This includes, but isn't limited to, LGBT+, asylum seekers and refugees, LD and Autism, children and young people (CYP) and older people. We should also seek to better understand how those marginalised by socio-economic factors are also disproportionately affected by the MHA.

A systematic data collection is important to allow us to establish a baseline, to allow us to monitor and measure the impact of different drivers of rising rates of detention, at different geographical levels, and the impact of interventions to address this. Without good data, policy makers and commissioners lack a critical resource to be able to make the case for change in practice or investment in new approaches.

¹⁴ A NSUN representative has been a member of the group and has articulated NSUN's views about the MHA. Whilst NSUN welcomes any reduction in detentions, NSUN's position is that legislation related to people with lived experience of mental health problems/mental distress needs to be fully compliant with human rights and so with the human rights enshrined in the UNCRPD.

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Research and evaluation

The topic group set out hoping to identify models and interventions where there was evidence of a positive impact on compulsory admissions, or overall admissions, which could be recommended for scaling up. However, through its work it has become clear that there is not a sufficient body of evidence to do this. Improved research and evaluation is needed to inform the design, commissioning and funding of services and interventions to tackle rising rates of detention.

This should cover both alternatives to detention in inpatient settings, interventions to prevent crisis or the escalation of crisis, and social factors that underpin crises. This needs to go beyond looking only at crisis care pathways and the short-term use of section 136, and should look at social factors, interventions and their shorter- and longer-term impact on all sections/ detentions, their duration, and longer-term individual outcomes. Evaluations need to look at a broad range of outcomes and benefits, including the views and experiences of service users, families and carers. It is critical that a fresh approach to research considers a broad range of types of evidence and evaluations. This needs to go beyond the traditional reliance on RCTs, in light of the historical dearth of formal research and high-quality evidence, and the undue weight which can sometime be put on them. We should also look to use evaluations more robustly and have methodologies developed that would allow meta evaluation, looking to approaches such as Realist Evaluation¹⁵ as a starting point. As far as is possible, research bodies should share iterative findings and learning from all MHA-related evaluations with services and professionals in real time to support continuous improvement and quality improvement approaches, thereby mitigating against the often very long lags in research that is in progress becoming applicable in practice and bridging the divide between researchers and practitioners.

A new focus should include user- and carer-led research and qualitative experiential information; it is clear from what the review has heard that many service users, families and carers know from their individual perspectives what precipitates a crisis and what helps to avoid one. This knowledge should be respected, harnessed and nurtured in formal research as well as more informal means through which mental health providers and local authority professionals should seek to work with service users, families and carers within their local catchment areas to understand and address uses of the Act. This includes when considering how evidence and evaluation is funded and commissioned.

¹⁵ See Pawson and Tilley.

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The MHA processes can be difficult and traumatic for service users, families and carers, and professionals. As a result, bridging the gaps between different groups' experiences is critical to help to address perceptions of power imbalances and create new spaces for collective, restorative dialogue. This should also help to bring the MHA more out of the shadows, to demystify and de-marginalise it as well as challenging the notions of the inevitability of detention. Specific groups and particularly marginalised groups experience assessment and detention differently, as do all individuals, and so any protective factors that may help avoid their detention (via social or clinical interventions) will also be different – we do not expect that there will be a one-size-fits-all solution or single intervention or model that will address the needs of all groups of people in a way that avoids use of the Act.

Alternatives to detention and interventions to prevent crisis or the escalation of crisis should be made available

The topic group has heard numerous examples of services or service models which service users, carers and professionals have identified as having been extremely beneficial, either in a time of crisis or in preventing crisis. These services are often Voluntary and Community Services (VCS) organisations, not-for-profit organisations and carers and service-user led organisations, and provide a range of care and support. This includes supporting people with, or at risk of developing, a serious mental health issue¹⁶ to address or manage factors which we know can trigger crisis, or limit recovery, such as housing and accommodation, relationships, and debt management.

Informed by the systematic collection of data and improved research and evaluation, the topic group recommends that more alternatives to detention and interventions to prevent crisis or the escalation of crisis are made available. This must go beyond 'an alternative', and must not be at the cost of core services. This should sit alongside much improved community services.

It is critical that we take a broad view when considering alternatives to detention and interventions to prevent crisis or the escalation of crisis. To help inform the work of the topic group, NSUN conducted a survey of its members to identify services users' perspectives of what they would have found helpful either in crisis or at risk of one, or which they would like to see in place. Respondents suggested that the key to recovery often is being heard and understood, receiving a compassionate approach, gaining access

¹⁶ The topic group is conscious of the tendency to use medical terminology when referring to the MHA. Some people with lived experience prefer to use alternative language, such as the social model of mental distress in line with the UNCRPD. Where mental health is referenced throughout this paper it aims to cover both views.

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to a variety of options and being offered support with reducing/coming off medication. This included access to user-led initiatives and/or initiatives which were non-clinically based and a number which were tailored towards people facing more than one type of disadvantage and/or internationally based.

While specific action can be taken to address rising rates of detention using system-wide and systems thinking on the back of improved data-based and formal-research-based understanding, we should not lose sight of the simple and logical conclusion that better, more accessible and responsive mental health crisis services and community-based mental health services that respond to people's needs and keep them well on an ongoing basis will help to prevent people reaching crisis. Alternatives to admission when people do experience a crisis should include social models which may be user-led or involve the VCS. As highlighted by the Human Rights and Equalities Group, 'the availability of genuine, appropriate, alternatives to detention, will also increase the likelihood that the decision to detain will not meet the human rights standard of 'necessary and proportionate', which could contribute to a decrease in detentions, and therefore minimise the human costs of detention, as set out above.

There is consensus that there needs to be significant improvements in community mental health services, including for people with whom traditional services struggle to engage. Disjointed, and under-funded, community services lead to more people falling through the gaps and ending up in crisis. People need to be able to access good quality community services quickly and consistently across the country, including via primary care.

These services should offer forms of personalised care and support, including, for example, proactive expert medicines management, social prescribing and psychological therapies, such as talking therapies, to connect people with a wide range of non-medicalised community-based activities. Currently, there is too much disparity in access to available services across the country. The sector also needs to harness the powers of technologies to allow people quicker and more flexible access to services, to support people to access services and support earlier.

The group has discussed at length concerns around the disparity of access to support and services of different disadvantaged groups, including but not limited to LGBT, BME, LD, asylum seekers & refugees. There are not currently sufficient community services or alternatives to detention. This is even more acute for these groups, as there are often barriers preventing them accessing the services that do exist. Individuals may be actively excluded, for example because they don't have recourse to public funding, or because their problems are regarded as too complex for services to manage. Even when individuals wish to access services and are able to do so, they often find services are not appropriate or have poor experiences, as they are not equipped to understand their needs, beliefs, backgrounds, culture etc in order to be able to provide appropriate care and support. These groups are often facing wider socio-economic disadvantage, which may

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make them more likely to become unwell, whilst at the same time less likely to access or get the care and support they need. Having a vibrant and varied offer of mental health services is critical to ensuring everyone has access to support and services to prevent crisis and detention.

Tackle the culture of risk aversion

We have heard many anecdotal reports that, over time, there has been a shift in the perception of acceptable risk and the 'risk appetite' among professionals, which may in part have contributed to the rise in the use of the MHA. This has for the most part been driven by professionals' fear of their non-intervention potentially leading to serious incidents and, at the most extreme end, deaths by suicide and the subsequent summons to coroners' courts to defend their chosen course of action, during inquest proceedings. This is a notoriously complex and emotive area as all professionals operate within a context that is delicately balanced, with lives as well as quality of life at stake. However, practice should not be driven by the individual fear of professionals and collective fear of organisations, but rather genuine and personalised co-production with people who use services, their families and carers, and shared-decision making as far as possible.

We need to move away from a situation where professionals are overly risk-averse, thereby overriding their better clinical, and social, judgement to the detriment of the liberty, human rights and individuality of service users and carers. Professionals need management, training support and supervision from their organisations and encouragement to adopt positive/therapeutic risk-taking approaches where possible. To do this will require a concerted, cross-organisation, drive to tackle the culture of risk aversion. This will need to include the Chief Coroner, CQC, NHSE, NHSI and trust boards, to understand the drivers of the current culture and how their functions and risk management can be improved to tackle this.

There is much room for improvement in the way that risk assessments are carried out. Risk, somewhat like capacity, is a dynamic and subjective concept, and risk assessments are rarely uniformly conducted, require a good amount of experiential knowledge and are not always helped by existing standardised assessment tools that work best for populations and rarely at the individual level. Going beyond this, there is a growing view from the suicide and self-harm clinical academic experts that the emphasis needs to be on safety, rather than risk¹⁷.

¹⁷ See for example: Chan et al (2016) and Nielssen et al (2017)

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The principle of the 'least restrictive option' that AMHPs should already adhere to generally regarded as a sound one¹⁸, and health organisations should engage more systematically with coroners to facilitate a shared understanding of decision-making processes and the drivers behind them. An initial action, as part of a much bigger drive, could see national bodies and medical leaders engage with the Chief Coroner and draw on the experiences of users, families and carers of detention to build the arguments for a culture of care rather than a culture driven by an unhelpful, unhealthy, unevidenced and disproportionate concern with risk framed negatively. It may take time for different parties to reach a point of understanding, but efforts to begin the process are needed now.

Public awareness strategy

There has been a welcome focus on mental health in recent years, however, this has tended to focus on the less severe end of mental health, and there remains a stigma around serious mental health issues. We have heard from service users and carers that this stigma can exasperate conditions or create a feeling of isolation. Building public awareness across the whole mental health spectrum could help address this.

Helping people to identify whether they, or someone they know, is at risk of a mental health crisis and what options are available should lead to more people getting help sooner, provided the appropriate services are in place.

The group believe the recommendations, set out above, have an important role to play in addressing the rising rates of detention, and in preventing the current inequalities and disparities in the system from perpetuating.

The group identified that the findings and recommendations for action would take us a few steps towards alignment with the recommendations made by the UN Special Rapporteur in his 2017 report (1) develop mainstream alternatives to coercion in policy with a view to legal reform; (2) develop a well-stocked basket of non-coercive alternatives in practice; and (3) develop a road map to radically reduce coercive medical practices, with a view to their elimination, with the participation of diverse stakeholders, including rights holders; (4) establish an exchange of good practices between and within countries; and (5) scale up research investment and quantitative and qualitative data collection to monitor progress towards these goals.¹⁹

¹⁸ This is not a universally held view. An NSUN representative has been a member of the group and has articulated NSUN's views about the MHA. NSUN would like to see an end to detentions occurring, again in line with the UNCRPD.

¹⁹ A/HRC/35/21, para 61.

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4. Implementation of recommendations

There are a number of critical areas to consider for the successful implementation of these recommendations.

Funding

If more alternatives to detention are to be made available, not at the cost of core services, then additional funding is likely to be needed. In the current climate we know this may be a challenge, which is why it is critical that first there is an investment in data collection, research and evaluation to inform spending. Once there is a better understanding of interventions which reduce detention we are confident that financial savings can be made when you consider that the average costs of detention is c£18,000, with an inpatient patient costing c£400 per day. Any reduction in detentions will also tackle the human costs of detention.

The group would also like to see the disparity in investment between physical and mental health addressed.

Workforce

Workforce remains one of the biggest challenges for the mental health sector. A vibrant, motivated, well managed and trained workforce is critical in ensuring people receive high quality care and making any alternatives to detention viable.

This should take a broad view, recognising the need for high quality traditional psychiatric occupations, as well as the critical role of peer support and those working in the third sector, and user-led services, who are vital to the delivery of a vibrant and varied market in services, as set out above. In doing so we should avoid taking a siloed view, and encourage workforces to learn from, and share with one another.

Provider market

Alternatives to detention, and improved community services, must consider the needs of the communities they support, and as much as possible, reflect them. To do this, variation and vibrancy within the provider sector is critical. A vibrant market encourages innovative commissioning and responds to the variety of people's needs, this includes carers who feel more involved in their caring roles, to the benefit of themselves and those they support and service users who feel better supported by more socially-oriented models of care.

In supporting a scaling up of mental health provision, the government, NHS England and commissioners need to ensure that there remains a space for smaller, innovative organisations and models and how they can be nurtured and sustained through innovative

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approaches to partnership and collaborative/alliance contracting. There are clear opportunities presented by the move towards place-based, population-based healthcare through Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) to understand individuals' journeys before, during and after the assessment and detention process, and to understand and address the social determinants of serious mental ill health in a collaborative way across NHS services, local authority services, VCS services, user-led services and communities themselves, including marginalised groups within communities. In transforming their crisis and acute care pathways, STPs and ICSs should ensure that NHS and local authority services harness the principle of the least restrictive option in designing alternatives to admission. STPs and ICSs have a much better chance of taking collective action than each of their constituent parts. One would hope that they will deliver provision which is better than the sum of the parts if barriers to collaborative working, slightly different geographical footprints and a lack of ability to share and link up data and other forms of intelligence, have been removed.

5. Evidence and analysis

07-Feb-18 [Draft]	Mental Health Policy Research Unit (MHPRU)	Review	'Scoping review of rates of detention and legal frameworks elsewhere in Europe: focus on any systems where rates are very low or have reduced.' Useful for 1A. Topic Group
29-Mar-18 [Draft]	MHPRU	Review	'Scoping review of all interventions to reduce compulsory admissions.'
16-Apr-18 [Final]	DHSC	Data analysis	Analyst Pack: Summary of data analysis by NHS Digital and MoJ
04-Sept - 18	NSUN	Service user research	Alternatives to detention: some suggestions from members of the National Survivor User Network (NSUN)
August	Topic group call for evidence	Evidence log	Summary of responses to the TG's call for evidence

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Maximising autonomy: consent to treatment

Chair: Sarah Hughes, Chief Executive, Centre for Mental Health

Working Group Lead: Sophie Corlett, Director of External Relations, Mind

Secretariat: Katy Lindfield, DHSC

Membership:

- Carey Bamber, Association of Mental Health Providers
- Dr Alison Brabban, Psychologist
- Akiko Hart, Personal capacity
- Marsha McAdam, Service user
- Nash Momori, Service user
- Camilla Parker, Solicitor
- Natasha Sloman, CQC
- Professor George Szukler, Professor of psychiatry
- Darren Watts, Carer

Terms of reference

Remit

The interim report said the Review would consider further:

Consent:

- 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 [...] treatment under the MHA, and at what points
- The potential for unintended consequences from different approaches to reform

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Advance planning:

- 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
- The potential for unintended consequences from different approaches to reform

The interim report also said: '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.' The Autonomy group will also consider the future role of Second Opinion Appointed Doctors.

The purpose of this group is to identify potential recommendations the review could make in relation to the above, and to support the review's overarching goals (see below).

The topic group will consider how current inequalities can be addressed in relation to the Mental Health Act, and any recommendations will consider the potential impact upon individuals identifying with protected characteristics under the Equality Act 2010. In particular, the review is seeking to address racial disparities, with a specific emphasis on people of Black African and Caribbean descent or heritage.

To explore: Models in other jurisdictions, including, but not limited to, Scotland and Northern Ireland

Timing and outputs

i. Review point:

- Gap analysis and any additional research requirements by 31st May.
- Progress update to the review by 31st July 2018.

ii. Final report

The group will produce a short report to the review leadership by 14th September 2018, using the agreed format, setting out key findings for consideration by the Review as they prepare their final report and recommendations to government.

The topic group's work will be supplemented by additional engagement activity.

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Interdependencies

- Care planning –in relation to advance statements and collaborative care-planning
- Tribunals, Hospital Managers, and Renewals –appeal rights and other safeguards are important to autonomy. The role of second opinion appointed doctors (SOADs) vis a vis tribunals will be of relevance to the Tribunals group.
- Advocacy – how can advocates facilitate patients' involvement?
- Patient dignity and safety – impact of positive ward culture
- CTOs - avoiding excessive compulsion

Review goals

- 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

Report

1. Issue

The interim report of the Independent Review of the Mental Health Act (MHA) found 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.

The group considered a number of aspects of autonomy in relation to consent to treatment, including on what basis refusals of treatment should be overridden, how to improve advance-planning while not losing sight of the problems that might arise from making any form of advance planning completely binding and how to improve shared decision-making. The group also considered the role of SOADs and other second opinions to strengthen safeguards in the first three months of detention and thereafter.

The starting point of the review as set out in the interim report was that there will be better outcomes for the service user if they can be empowered to make as many decisions for themselves as possible, and where they are subject to compulsion, to have a say in as many aspects of their care and treatment as possible. Improving and strengthening the provisions which enable patients to have a say in their treatment should therefore improve experiences and outcomes.

2. Findings

In making its recommendations the group first sought to define autonomy it agreed that it should be defined in the following ways:

1. **Autonomy as the right to self-determination:** Individuals have the legal right to make decisions for themselves. This engages the question whether mental health legislation should permit an individual's refusal of treatment to be overridden even if they have the capacity to make such treatment decisions for themselves.
2. **Autonomy as the ability to make decisions for oneself:** This engages the question of how the ability to make decisions, such as treatment decisions, is determined. For example, the Mental Capacity Act 2005 sets out the basis on which individuals are assessed as lacking the mental capacity to make decisions for themselves.
3. **Autonomy as the reflection of individuals' wishes and feelings** irrespective of a finding that they lack the mental capacity (or in the case of under 16s the competence) to make the decision in question. The courts are increasingly highlighting the importance of seeking and considering the wishes of individuals who lack the capacity to make decisions for themselves. This is also emphasised in human rights standards.

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The recommendations seek to address all three of these aspects of autonomy.

The group considered:

- When capacitous refusals of treatment could be overridden and the weight given to preferences expressed with capacity
- How to strengthen and improve the take-up of advance decision-making documents (ADMDs) including self-binding ADMDs
- How to improve shared-decision making to ensure that patients' will and preferences were taken account of in the development of care and treatment plans
- How to improve safeguards through the extended use of SOADs

A. Taking Patient's Treatment Views into account.

Recommendation 1 – Making it harder to override capacitous refusals and preferences

The group considered the basis on which consent, refusals and expressed preferences for treatment should be taken into account. It considered evidence that patients often feel that they are not listened to in relation to their treatment and that their refusals, wishes and preferences were overridden. It concluded that it was too easy to override refusals and expressed preferences under the current MHA provisions and that these should be tightened. Alongside this and to ensure that individuals were making informed decisions the group recommended that absolute capacitous refusals of treatments should only be given with full knowledge of the potential consequences of that decision to ensure those decisions were fully informed.

Recommendation 2 – Capacitous refusals and preferences expressed in advance and in real-time to have the same weight

The group considered whether different weight should be given to capacitous decisions made in advance and those made in real-time. It concluded that refusals should only be accepted where an individual had capacity and a full understanding of the consequences of refusals.

If these criteria were met then the same weight should be given to refusals whether they were made in advance or in real-time.

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Recommendation 3 – A tiered approach to decision-making

The group considered that as well as tightening up the process for overriding capacitously expressed refusals or preferences there should be, as now, more stringent safeguards for certain treatments. Its final recommendation was for a tiered approach to decision-making. The table at Annex 1 provides details of this approach. In short it provides that:

- **Category 1** - The current provisions for neuro-surgery should be retained and extended to include Deep Brain Stimulation (DBS).
- **Category 2** - That the provisions around ECT are strengthened to provide that it cannot be given in the face of an absolute capacitous refusal (either given at the time or made in advance) and it may only be given without capacitous consent where the urgent criteria set out in the current section 62(1)(a) and (b) (treatment life-saving or preventing serious deterioration).
- **Category 3** - That other capacitous refusals can only be overridden where the urgent criteria are met or where other strict criteria are met (including, for instance, that no alternative, more acceptable, treatments are available that would lead to similar improvement in the condition and/or that the treatment is necessary for improvement of the condition) and with SOAD approval.
- **Category 4** - That practitioners must have regard to capacitously expressed preferences and where these are not followed this should be recorded and may be subject to CQC inspections.

Additional recommendations:

- non-treatment preferences including those expressed in crisis plans should be followed as far as is practicable.
- the needs of people from BAME backgrounds were particularly understood within this context, translation, BSL and other communication tools to be available at point of assessment of capacity and treatment.
- absolute capacitous refusals of treatments can only be authenticated where there is confidence that the individual has full knowledge of the potential consequences and that the refusal valid and applicable.

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Discussion 1 – Use of ECT

In deciding to allow absolute capacitous refusals of ECT the group considered the significant harm to long-term well-being and health the procedures could produce and the opposing evidence on the efficacy of ECT.

The group considered arguments that ECT should be overridden in the face of absolute capacitous refusals in urgent cases as now (ie section 62(1)(a) and (b)). However, the view was that this should not be allowed. The group recognised the recommendation was likely to be controversial and understood that further consultation and consideration of this issue is likely to be necessary.

Discussion 2 – Category for naso-gastric feeding

In relation to Naso-gastric feeding the potential physical and psychological harm to the patient was considered against the need for urgent treatment. Weight was also given to the need for trust to be built up between professionals and a patient for longer term recovery to be successful. The group considered whether naso-gastric feeding should be category 2 or category 3 or whether a new category would be necessary to enable absolute capacitous refusals to be overridden on the urgent treatment criteria (category 2a) but did not reach a consensus. The review should consider in which category naso-gastric feeding should fall.

Recommendation 4 – Use of best interests criteria when considering treatment for those without capacity:

The group considered how best to ensure that the will and preferences of those without capacity could be taken into account. It agreed that in these cases:

- the best interests process set out in section 4 of the MCA should be followed in making treatment decisions.
- that this should not however override any more stringent criteria set for specific treatments (eg those for Category 1 and Category 2)
- that unauthenticated ADMDs or ADMDs completed without capacity should be considered as part of section 4 criteria.

Additional recommendations:

- The group considered the current criteria for urgent treatment (section 62) it agreed that these should be tightened to limit the number of times and the period of time (eg 48/72 hours) over which the provisions could be used. However, it did not make firm recommendations on what these should be;

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- The group also agreed that when deciding whether treatment fits the criteria practitioners must consider the evidence base for that treatment (this may be for instance by using NICE guidelines); and
- That the treatments included in the Categories 1 and 2 should be set out in regulations so that they can be more easily added to as appropriate.

BAME recommendation – Formal Impact Assessment

In the case of BAME patients the group would like a formal impact assessment on the impact of these recommendations.

B. Advance Decision-Making

Recommendation 1 – ADMDs to be put on a statutory basis

The topic group agreed that enabling an individual to make decisions about their treatment when they had capacity, so that they can be identified when they lacked it, would have a significantly positive impact on that individual's autonomy. The group agreed that ADMDs should be put on a statutory basis. Its proposals are described in the document at Annex 2. In short it recommends that there should be the provision to:

- Require information on ADMDs to be publicised to raise awareness (including in patient information packs)
- Enable individuals to be able to request ADMDs
- Require practitioners to offer ADMDs to specified individuals (the group agreed that as a minimum this should include those who have been previously detained, those with fluctuating decision-making capacity and those on the CPA but that further consideration should be given to what other groups should be included)
- Require IMHAs to support the development of ADMDs unless the patient refuses (ie opt-out provision)
- Enable the authentication of ADMDs by specified professionals (as set out in regulations) if it is written with capacity and the individual consents to it. In the case of absolute refusals this should also include a signed statement or disclosure (potentially supported by evidence) that the individual fully understands the consequences of the refusal

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- That authentication could not be denied because a clinician disagreed with the individual's choices
- That refusals of treatment and treatment preferences be treated as set out in recommendation 1 above.
- Require authenticated ADMDs to be stored, with consent, on a database accessible to all relevant mental healthcare workers including certain elements to be available, with consent, to police/social care, and to be kept with the patient's records
- Keep the ADMD with the patient's record and include a flag that the patient has an ADMD on their electronic records.
- Enable review of ADMDs at specified times (eg following use, as part of care-planning, on request, every 12 months)
- Require monitoring of provision, development and non-adherence of ADMD by CQC

Additional recommendations:

- 16/17-year olds with capacity and under 16s who are assessed as being able to make their own decisions about their care and treatment should be able to have authenticated ADMDs
- Any non-authenticated ADMDs whether completed by those without capacity or by those who did not agree to authentication should be considered by practitioners as part of a section 4 best interests assessment.
- That consideration needed to be given to the terminology used for ADMDs to avoid confusion with other existing advance statements/decisions etc.

Recommendation 2 – Information contained in ADMDs

The group also considered what information the ADMDs should include and there was a strong consensus that in order to support person-centred care, ADMDs should include:

Statements

- the name of the nominated person (if any),
- treatment refusals; and
- treatment preferences (including non-medical treatment such as talking therapies)

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Personal information

They should also include personal information including any of the individual's:

- values and beliefs
- religion
- culture

Important information

- previous trauma or other relevant past experiences or disadvantage
- who they wished to be informed/involved in their care (if anyone)
- physical health needs
- communication preferences
- behavioural triggers if any
- practical issues in relation to crisis planning
- DNRs could not be included in the ADMD.

Discussion 1 – Refusals of detention

There was also discussion of the proposal included in the King's College London report, commissioned by the Review²⁰ that a person should be able to include a refusal of detention in their authenticated ADMD, which would have the same weight as refusals to treatment. There were some concerns about this because: it raised the prospect of different criteria for detention being applied for those with ADMDs and that if the bar for detention could be higher or lower for this group, it should be higher or lower for all. There was also concern that these refusals might inadvertently lead to services finding more reasons to neglect the health and wellbeing of some people who they have found it harder to engage with.

²⁰ Report for the Independent Review of the Mental Health Act: Advance Decision-Making in Mental Health' Owen, G.S. et al. (publication forthcoming)

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Discussion 2 – Developing an ADMD

There were also discussions on how the ADMD should be developed. Suggestions included that it be developed with a multi-disciplinary team and with senior clinician involvement to give the document weight, there was also support for an advocate led process to ensure independence and there was a suggestion that legal input could be required to support patients to develop ADMDs (this would particularly be the case where the ADMD included advance consent).

Discussion 3- Advance consent

There was discussion on whether advance consents for treatment in the first two categories (eg Neuro-surgery and ECT could be accepted. The group did not agree on whether this should be possible (those against arguing that advance consent can never allow for the particular circumstances in which decisions are made) but did agree that if it were included there would need to be stringent safeguards to ensure that the consent was informed and given with full understanding. Suggestions for this included the presence of a solicitor or advocate for authentication of consent, that consent was based on previous experience and there would be no obligation on an individual to include any form of advance consent in their ADMD.

Discussion 4 - Self-binding ADMDs

Self-binding ADMDs which would enable individuals to set out the circumstances in which they should be admitted to hospital for care and treatment were also considered. The group approved the concept of individuals being able to identify in advance when they needed to be admitted to hospital. Discussions centred around whether such patients should be informally admitted or whether ADMDs should identify the behaviours which demonstrated that a person met the criteria for detention and should therefore lead to formal detention under the MHA meaning that individuals would benefit from the safeguards of that Act. The majority view was that the latter approach should be adopted, however some in the group questioned whether someone who has, in effect, consented to admission could be detained. Further consideration and engagement is required to agree how self-binding ADMDs should operate.

C. Shared decision-making

Recommendation 1 – Care and Treatment Plans developed using collaborative care planning for all patients

The group considered how autonomy could be further improved for those receiving treatment under the Act. It considered the Rethink Mental Illness' Report 'No Voice, No Choice?'²¹, and the COCAPP-A study²² which looked at the experiences of patients and staff in relation to care-planning. The group concluded that improving the provision of shared decision-making was key to increasing autonomy for patients. It considered issues which could help to support this and recommended that all patients should have a care and treatment plan developed using collaborative care planning and that in developing the plan there should be a duty to ascertain the feelings, wishes and preferences of the patient.

The group considered issues which would help to support this and recommended that the following should be included in guidance:

Approach:

- patient-centred approach respecting their beliefs and values, will and preferences
- planning based on an individual's needs,
- using trauma-informed approaches and taking a patient's past experiences into account
- using recovery-focussed language
- focus on relationship building
- planning for discharge as part of the initial detention

²¹ No Voice, No Choice? Making the Mental Health Act more person centred, Rethink Mental Illness, Adelphi Research UK, April 2018

²² Cross-national mixed methods comparative case study of recovery-focused mental health care planning and coordination in acute inpatient mental health settings (COCAPP-A). Health Services and Delivery Research, Simpson, A., Coffey, M., Hannigan, B., Barlow, S., Cohen, R. L., Jones, A., Faulkner, A., Thornton, A., Vřetečková, J., Haddad, M. and Marlowe, K (2017)., 5(26), doi: 10.3310/hsdr05260

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- the participation of voluntary or third sector organisations which may be involved with the patient in the community in their care planning

Involvement/rights of patient:

- care-plan written with patient and must not be signed off in patient's absence (unless incapacity prevents attendance)
- using everyday language in discussion and in the care plan itself
- patient supported by an advocate unless they refuse (ie opt out)
- ensuring that patients, and where appropriate their carers/families, are involved in conversations about risk/safety is the standard
- patient should have access to their electronic care plans and records which, as set out above, should be written in everyday language
- ensuring patients know about their rights to co-produce their care plan and are actively supported to assert that right and to engage effectively in the development process.

Equality and diversity:

- special consideration must be given to an individual's culture and beliefs, and race. Practitioners should pay particular attention to unconscious bias and discriminatory practice and these requirements should be set out in legislation.
- the importance of considering transition for young people from children's services to adult mental health services / social care
- ensuring that an individual's physical needs are considered as part of care planning
- the need to make adjustments for individual's communications need eg use of BSL, braille etc., translation, or for example, breaking down the discussion into smaller elements to enable involvement of those who are very unwell or confused.

Contextual understanding:

- The need to acknowledge and considered experience of trauma
- Ensuring that communication took cognitive needs into account
- The Impact of crisis on an individual

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Review and monitoring of care plans

- care plans reviewed on ward rounds with patient
- CQC monitoring of trusts approach to care-planning

Issues considered:

The group also considered that the following could help to ensure effective shared-decision-making:

- Staff training and support
- Mandatory Human Rights training for staff
- Mental Health Act training for staff
- Training in the social model of care
- The key inclusion of service -users in the development and delivery of staff training
- The use of guidelines and/or checklists to record and support planning

Other issues raised in this discussion included:

- The development of a role similar to that of appropriate adult to support shared decision-making which would have similar skills to an advocate but could come through different resource models including through third sector organisations
- That there needed to be safeguards against this approach leading to neglect eg where an individual refused to engage with services (the duty of care was raised here)
- That staff need to be comfortable giving autonomy to patients and to do this they needed to be given autonomy themselves.
- The key importance of culture and leadership
- The need to ensure that shared-decision making and collaboratively developed care plans were not ignored when a patient was detained

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Discussion 1: Overriding preferences made in advance

The group considered whether non-capacitous preferences expressed in real time should be able to override preferences expressed in advance with capacity.

As part of this discussion the group agreed that this should be allowed in certain circumstances, for example, where a person was now making a cogent decision based on experience that they did not have at the time of making the ADMD, and that section 4 of the MCA should be used to make best interests decisions in these cases.

In addition, the group considered that in these cases there would need to be stringent additional safeguards such as the involvement of SOADs and consultation with the nominated person, carers, advocates etc to ensure against coercion.

D. Use of SOADs/second opinion

The group considered how safeguards could be improved by strengthening second opinions. In particular to close the three month gap which puts the MHA at odds with emerging case law on Human Rights and to provide an easier route through which patients could seek reviews or approvals of decisions made about their treatment. It was considered that these recommendations were particularly important in relation to mitigating the experience of over represented groups such as BAME individuals in acute care.

Recommendation 1 – Role of SOADS and second review

The group discussed when an official SOAD review should be used and when a second opinion could be considered. It recommended that:

- SOADs must be used when approval of treatment is required and when confirmation is sought that the emergency use of ECT was correct.
- Second opinions should be used to review treatment
- Clinicians must have regard to second reviews of treatment but should not be bound by them
- That whoever undertook a second opinion review must be independent

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Discussion 1 – When second opinions should be used

The group discussed when it might be appropriate for a second opinion review. Suggestions included, at the request of the patient and after significant changes to the care plan.

Recommendation 2 - Extended role for SOADs

The group concluded that to increase safeguards the following should be triggers for SOAD review:

- To approve neuro-surgery or DBS (as currently for neuro-surgery)
- To provide independent confirmation, following use of ECT that the urgent criteria set out in section 62(1)(a) and (b) were met
- To review certificates given (as now)
- Within 72 hours of a detention care and treatment plan being agreed.
- To approve any overriding of category 3 refusals
- At specified intervals (eg every 2 months) if a SOAD has not been triggered by one of the above

Discussion 2 – SOADs as gateway to tribunal

There was some discussion of whether the SOADs should also act as a gateway to Tribunal access though no firm recommendations were made the group did consider that the increased use of SOADs may make such a requirement redundant. The review may wish to consider the role of SOADs in tribunals alongside the recommendations of the tribunal group.

Discussion 3 – Consideration of whether detention under MHA is necessary

The group also considered that the 72-hour review should also be taken as an opportunity to consider with the patient (and others as appropriate) whether informal admission is more appropriate so if the patient has been admitted under section 2 the second opinion review should also consider whether the patient should continue to be detained or can be admitted informally eg where following review the patient agrees to the care and treatment plan.

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Discussion 4 - Who can undertake second opinions

The group agreed that SOADs should, as now, always be doctors contracted by the CQC. However, there was discussion about whether other second opinions need always be undertaken by a doctor. There was a general consensus that in some cases these could be undertaken by for example a psychologist (where non-medical therapies were being considered) or a pharmacist with knowledge of the specific medicines being reviewed.

Recommendation 3 - What reviews should consider

The group discussed what a review (both SOAD and second opinion) should consider using the first-hand experiences of the service users and carers on the group to inform their consideration. It recommended that:

- in undertaking the review, the second opinion should look at all aspects of the care and treatment plan including the diagnosis where this was disputed by the patient, all treatment including therapies and, in particular, how the individual's physical needs are being met.
- that second opinions should consider the issues currently listed in the Code of Practice para 25.62) and that these issues should be included in statute.
- reviews must consider the values and beliefs of the individual

Other suggestions raised during this discussion were that:

- where the responsible clinician (RC) and the second opinion doctor did not agree a SOAD could be called in.
- advocacy should be included as part of any review
- that each trust should employ a senior clinician to act as an independent reviewer of care and treatment decisions and that this clinician could ask other professionals including pharmacists or psychologists to undertake the review on their behalf.

Recommendation 4 – Improving recruitment and quality of SOADs

The group also considered concerns that there were long waits for SOAD's due to insufficient numbers and concerns about their independence and quality. Their recommendations on this were for:

- Improved training
- A review of pay rates

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- Removing second opinion work for the MHA from the list of activities prohibited under NHS contracts as this restricts the numbers of people able to apply for work as SOADs.

3. Rationale

In making decisions about autonomy the group considered a number of papers including the findings of the COCAPP/A research on care-planning, 'No Voice No Choice' research by Rethink Mental Illness and the Kings' College London report on advance decisions which was commissioned for the Review. These documents provided evidence on the detrimental impact on patients of not being involved in decisions made about their care and treatment the appetite for increased participation and involvement and in particular for ADMDs and made recommendations on how to achieve this.

In line with the terms of reference of the Review the group also consider that the emphasis of the recommendations on taking the individuals values and beliefs into consideration at every stage will provide an extra layer of support/safeguards for people from BAME groups.

Scale/scope of the option/ intervention

Providing for a strengthened autonomy will potentially positively impact all individuals at risk of detention.

Funding/ costs

Implementation costs will include education and training and the potential development of consistent forms for both care planning and ADMDs and the amendment of existing forms to record their consideration. These should be costed as part of the wider education and training necessary to implement the proposed changes to the Act.

There may also be implementation costs related to the development of a chapter on ADMDs and shared decision-making for the MHA Code of Practice. This should also be costed as part of the wider changes to the code necessitated by the amended Act.

Preparing, recording (including recording non-adherence) and reviewing care planning and ADMDs will represent an additional burden on clinicians and their teams representing a cost to the NHS.

If a national database is established there would be a cost to develop and maintain it (cost to central Government).

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The extended role of IMHAs could require that more are recruited this would be a cost to local authorities and should be considered as part of the wider reforms of IMHAs.

There may also be a cost to CQC if its monitoring remit is extended to ADMDs and care planning.

If it is considered that legal advice should be available to those developing ADMDs then this would represent cost either to patients or Government (if the decision was to allow this to be covered by legal aid).

Training and recruiting additional SOADs or individuals providing second reviews will also represent a cost.

However increased autonomy should lead to improved experiences and outcomes which could lead to reduced time spent in detention and a fall in the rate of readmittance representing a saving to the NHS. Increased involvement in decision-making may also lead to a reduction in SOAD reviews and appeals to Tribunals. We would recommend that further work is done to consider the impact of increased autonomy on the experience of patient's care, their length of stay and their likelihood of readmittance.

The group expects an improvement in access to translators, British Sign Language, and other communicators at the point of emergency. This may require extra resource and infrastructure costs for trusts but may reduce subsequent costs as better decisions may be made at an earlier stage.

Support/challenge

As set out above there is wide agreement that increasing autonomy for patients is a positive goal. However, there may be some push back to the continued ability to override refusals of treatment and the requirements for authentication and additional recording.

Some have argued that there should be more right to refuse treatments, based on human rights. We have not agreed with this interpretation

Dignity and respect

As set out in the interim report the Review comes from the position that increasing a user's say and involvement in their care and treatment will improve their outcomes. These recommendations should support that. We have developed an opt out approach to ensure the responsibility is not on the individual to know that they have the right to, for instance, request an ADMD.

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Detention rates

A greater emphasis on autonomy and involvement could lead to individuals being less likely to be detained under the MHA and to fewer examples of multiple detentions due to improved experiences and outcomes.

Equality considerations, Black, Asian and Minority Ethnicities (BAME), Other

The group is aware of the specific issues impacting those with protected characteristics particularly black patients. They felt that as representation on the group was low from BAME groups they were not able to consider these issues in detail and it is recommended that the review ensures that all recommendations undergo an impact assessment by the BAME practitioner and service users group or another identified process. We also recommend that a public focus group is consulted and involved in the development of final recommendations on increasing autonomy.

4. Implementation of recommendations

- The MHA would need to be amended to provide for increased autonomy including regulation-making powers to enable those treatments for which refusals are absolute or for which certain criteria must be met before they can be overridden to be listed.
- There would also need to be amendments to the MHA Code of Practice to reflect the changes to legislation
- Training and education would also be required this could be implemented through our mandate to Health Education England (HEE), with NHS England or for IMHA's City and Guilds.
- Any national database might need to be commissioned (potentially from NHS Digital). Alternatively, were trusts to be directed to purchase a particular database (it could be one of several existing databases). there would need to be training on its use.
- Amendments to patient records to enable ADMDs to be placed on them and /or an electronic flag on patient records would also need to be implemented via NHS Digital.
- In order to implement these changes, we would need to engage with local authorities (for IMHAs), and professional groups such as RCPsych, Mental Health Trusts, Community Mental Health Services (to support the development and recording of ADMDs), A&Es and potentially police and the Criminal Justice System. Education providers and trusts would need to be involved along with NHS Digital to provide that ADMDs/care plans can be accessed. CQC would need to be involved in its role as regulator of the system.

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- In order for this option to have maximum impact best practice on care planning would need to be implemented consistently across the mental health system. There would also need to be systems in place to enable the easy sharing and access of all care plans including ADMDs. Practitioners should also be properly trained and educated in the system.

- We also recommended a BAME impact assessment to assess the potential impact

5. Evidence and analysis

The independent review commissioned research on advance decision-making (reference above). This found that there were high-levels of agreement amongst those in health policy that advance-decision making should be improved and extended.

The research also looked at service users views on advance decision-making. It found that 'most data is from the USA with sampling from community mental health services for severe mental illness (Swanson et al. 2003, 2005; Swartz et al 2005; Elbogen et al. 2006). In all of these studies a majority (>50%) express positive views about mental health advance decision making. In England and Wales a Mental Health Alliance survey of 1218 people with mental illness who had experience of MHA detention found that 889 (73%) thought ADRT should be the same under MHA as MCA. A survey of 932 subscribers to Bipolar UK with experience of Bipolar (Hindley et al. unpublished) found that 88% wanted any ADM and that 69% wanted self-binding ADM with collaboration with a psychiatrist. Studies report a large mismatch between actuality (what people with mental illness are doing) and aspiration (what they would like to do) on ADM.'

Support for strengthened autonomy was a feature of the workshops and a number of the focus groups held to support the review.

Annex 1: Overriding refusals of treatment/treatment preferences

1. The Maximising Autonomy: Consent to Treatment Topic Group has been developing recommendations to improve autonomy across the Mental Health Act. It has looked in particular at Advance Decision-Making, Collaborative Care Planning/Shared Decision-Making and the use of second opinions/SOADs.
2. Key recommendations on each of these subject is the criteria that should be adopted to ensure that patient's expressed views, preferences and refusals of treatment are given appropriate weight under the MHA. We want to ensure that the approach we choose is consistent across ADMDs and shared decision-making and that SOADs use the same criteria for assessing care and treatment decisions as those used by the clinicians making the decisions in the first place.
3. The following table reflects the topic group's recommendations:

	What is in scope	Obligations	Limits
Treatment consents, refusals and preferences			
Category 1 Treatments requiring authenticated capacitous consent and safeguards	Defined in regulations. Recommended: neurosurgery, DBS	Existing section 57 safeguards continue to apply	None
Category 2 Treatments requiring authenticated capacitous consent	Defined in regulations. Recommended: ECT,	Treatment cannot be given in the face of authenticated ADMD refusals or contemporary refusal Treatment can only be given Either: With patient's authenticated capacitous advanced consent or contemporaneous capacitous consent	Where no absolute refusals are present treatment can be given without consent if urgent treatment criteria set out in s62(1)(a) and (b) are met (s62). Though only for specified number of times or within specified number of hours (eg 48/72) The decision to treat under s62(1)(a) and (b) must be set out in writing on the care plan and be lodged with the hospital Mental Health Act Manager.

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		<p>(as in current s58A (3))</p> <p>OR</p> <p>If the patient lacks capacity where s62(1)(a) and (b) urgent treatment criteria are met, with limits based on number and frequency of treatments and following a Best Interest Assessment.</p>	<p>Justifications will be subject to SOAD consideration and CQC inspection.</p>
<p>Category 3 Refusals</p>	<p>Recommended: all other medications, and psychological therapies</p>	<p>Capacitous contemporaneous refusals or authenticated advance refusals are binding with exceptions</p> <p>Where patient does not have capacity or authenticated ADMD section 4 of the MCA applies and will and preferences will be ascertained and considered as part of that.</p>	<p>Exceptions are either:</p> <p>urgent treatment criteria (s62)</p> <p>OR</p> <p>Criteria relating to the necessity of the treatment, the availability of optional treatments AND with the sign, off from a SOAD.</p> <p>The decision to overrule a refusal must be set out in writing on the care plan and lodged with the hospital Mental Health Act Manager. Justifications will be subject to CQC inspection.</p>

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Category 4 treatment preferences	Any preferences about preferred medication, psychological therapy, etc.	Lead clinician must have due regard to these preferences whether authenticated or not Or Where patient does not have capacity or authenticated ADMD section 4 of the MCA applies and preferences will be ascertained and considered as part of that process.	Lead clinician must document and justify any variation from expressed preferences. Justifications will be subject to CQC inspection.
Self-binding requests			
Detention request	Preference to detain and treat if person displays certain specified behaviours indicative of approaching mental health crisis/loss of capacity/when detention criteria is met	See Report	See Report
Care and other preferences –			
Care preferences	Preferences about other aspects of care: eg values and beliefs, religious observances, dietary requirements.	Trust/provider to view as binding if covered by Equality Act Providers and practitioners to adhere to as far as is practicable	
Crisis preferences	Preferences regarding home circumstances eg, who should be kept informed, care of dependents and pets, etc.	Providers and practitioners to adhere to as far as is practicable	
Nominated Person	Nominated Person	To be agreed by relevant Topic Group	

Annex 2: Advance decision making documents

Summary

1 This paper outlines proposals from the Increasing Autonomy/Consent to Treatment topic group for the introduction of statutory advance decision-making documents (ADMDs). The proposal would put a statutory requirement on professionals to offer and review ADMDs for certain groups of people at certain times and allow for patients to state both their preferences and refusals. Departure from authenticated ADMDs would be allowed under specific conditions and would need to be recorded.

Outline

2 There should be a statutory requirement on Trusts to offer ADMDs to:

- Anyone who has been detained in the past (this to be initially broached as part of aftercare planning, but if not taken up, the offer should be made regularly following discharge)
- Anyone on the Care Programme Approach (CPA)
- Anyone who has in the past been unable to express their settled views due to fluctuating capacity and/or has been referred for an ADMD (potentially this might be from a GP, Liaison and Diversion services or Psychiatric Liaison in A&E)

3 Anyone with a mental health problem can request an ADMD and the involvement of a clinician in developing it and this request must be considered by the person's GP or community team.

4 There should be a statutory responsibility on trusts to ensure people eligible to be offered an ADMD, and others liable to want an ADMD, know about the option of having an ADMD, are provided with accessible information about ADMDs and that the option or producing an ADMD is raised regularly with patients by staff. Records should document that this discussion has taken place and ward welcome packs should include information about ADMDs and their role.

5 An ADMD should be drawn up as part of wider care planning where possible and with the involvement of a multi-disciplinary team.

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6 Capacitous 16 and 17 year olds and those under 16 with the ability to decide should also be able to have Authenticated ADMDs in the same way as adults.

7 Advocacy should be provided on an opt-out basis to support people when developing an ADMD. They should also be able to involve friends or family as they wish and receive support from a solicitor if necessary. Though it is acknowledged that this may not be possible if legal aid is not available and that this may have a negative impact on the patient.

8 An ADMD should be reviewed at any time that the care plan is reviewed and after any period of detention or when the ADMD has been brought into use, and every 6/12 months. A person may request a review at any time but has no automatic right to support or authentication outside these times.

9 The group identified that some care plans are never fully "signed off" which could cause a delay/permanent delay of an ADMD. It was proposed that while the clinician might start off the process with the authentication of capacity and discussion about treatment, the rest of the document could be completed with an administrator.

10 An ADMD can cover any or all the following:

- Nominated persons
- Treatment preferences (including medications, specific medications and other therapeutic approaches)
- Treatment refusals
- Religious or cultural requirements
- Other health needs or reasonable adjustments for disability
- Crisis planning, including information about care of children or other dependents, employment, housing, pets or people to contact
- Any self-binding requests.

We would recommend a standard template be produced to cover the above and to provide assurance that where the individual has specified refusal of treatments which are absolutely binding they understand the implications of that refusal. The development of an agreed template should not delay the production of ADMDs.

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11 Where the treatment preferences and/or refusals are agreed with the clinician or team this should be stated in the document. However, the patient's preferences, consents and refusals should be set out clearly whether or not they are agreed by the team.

12 If the person has capacity to state their preferences while developing the ADMD, this would be "authenticated" by anyone included in regulations (but to include a clinician involved in the development of the ADMD, nurses, OTs and solicitor) and recorded in the document. A person without capacity is not prevented from drawing up an ADMD, but such a document would not be authenticated.

13 With the consent of the patient, ADMDs should be stored on a national database (this could be an existing database that is rolled out) and on the home Trusts own records database with the patient's medical records or as a fall back, the existence of the ADMD should be recorded on the national database with the ADMD itself being lodged with the home Trust. The patient may take copies for themselves or others, or request copies be given to specified services or clinicians. Where a patient has an ADMD this should be flagged on their electronic record

14 With advance permission of the patient, elements of the ADMD, in particular the crisis preferences, should be made available to the police in a crisis situation via triage or other health liaison staff.

15 Clinicians should have a responsibility to check for the existence of an ADMD and access this when someone is in crisis or the MHA may be used.

16 As now, certain treatments should only be administered with the patient's consent. The weight which refusals and preferences in the ADMD should be treated can be found at Annex 1 above.

17 There are a significant group of people, including people with fluctuating decision-making capacity, who are interested in self-binding ADMDs that would request detention and treatment at a future point when they lack capacity. The ADMD might provide a different interpretation of their condition allowing them to be brought within the criteria and so be detained. This might be difficult to achieve if the main risk from the condition were to the person's relationships or financial position, and particularly so if the detention criteria are narrowed by the Detention Criteria Group. Alternatively, it might allow for the criteria to be widened for this group. The Review may wish to consider this further. This could be restricted to those who have a prior pattern of relapse.

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Detention criteria

Chair Colin McKay, Chief Executive, Mental Welfare Commission for Scotland

Working group lead: Andy Bell, Deputy Chief Executive, Centre for Mental Health

Secretariat: Sarah Palmer, DHSC

Membership

- Dr Ruth Allen - CEO British Association of Social Workers
- Dr Arun Chopra - Consultant Psychiatrist
- Sophie Corlett - Mind, Director of External Relations
- Dr Anne Felton - Associate Professor, University of Nottingham
- Dr Sarah Markham - Visiting Researcher King's College, London
- Annabel Price - Vice Chair Faculty of Liaison Psychiatry, Royal College of Psychiatrists
- Carolyn Taylor - solicitor in mental health law and Mental Health Tribunal Judge

In addition to the core members, the topic group may bring in expert contributors for specific issues within the topic, or to test emerging findings.

Terms of reference

Remit

The interim report said the review will consider further:

- Whether Section 2 (detention for assessment) and Section 3 (detention for treatment) of the Mental Health Act should be combined or reconfigured
- Whether and how a person's decision-making ability and mental capacity should play a clearer role in decisions to detain
- Whether current risk thresholds under the Mental Health Act are the right ones, and if not, what they should be

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- How the Mental Health Act can support positive risk taking and standardised/operationalised risk assessment when making decisions for detention and renewal of detention
- Whether the requirement for appropriate treatment to be available is effective in ensuring a person receives clinically and psycho-socially effective help while being detained, and if not, how the criteria might be properly described

The topic group will consider how current inequalities can be addressed in relation to the Mental Health Act, and any recommendations will consider the potential impact upon individuals identifying with protected characteristics under the Equality Act 2010. In particular, the review is seeking to address racial disparities, with a specific emphasis on people of African and Caribbean descent or heritage.

The purpose of this group is to identify potential recommendations the review could make, in relation to the above and to support the review's overarching goals (see below).

The interim report expressed concern about "the risk that a person with a mental disorder could be detained for a prolonged period of time without the possibility of treatment". The report also said "We have... 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."

To explore: The Scottish model of 'significantly impaired decision-making ability' as a criterion for detention, and similar approaches.

Timing and outputs

i. Review point:

Progress update to the review by end July 2018.

ii. Final report

The group will to produce a short report to the review leadership by 14th September 2018, using the agreed format, setting out key findings for consideration by the Review as they prepare their final report and recommendations to government.

The topic group's work will be supplemented by additional engagement activity.

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Interdependencies

- MCA interface topic group – looking at the role of mental capacity at the point of detention (including ‘fusion’ models)
- Tribunals Hospital Managers and Renewals topic group - will consider the processes and safeguards relating to renewal and applications for discharge.
- Maximising patient autonomy topic group – will consider the legal basis for documented ‘advance decisions’, and risk aversion in wider decision-making under the Act.
- Learning disabilities and autism topic group –this group will be considering the relationship between these conditions and the definition of ‘mental disorder’ in the Act.
- Criminal Justice System – whether any new criteria should sit in both Part II and Part III of the Act.

Goals set out in the review’s interim report

- 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

Report

1. Issue

Our terms of reference asked us to consider:

- Whether Section 2 (detention for assessment) and Section 3 (detention for treatment) of the Mental Health Act should be combined or reconfigured
- Whether and how a person's decision-making ability and mental capacity should play a clearer role in decisions to detain
- Whether the requirement for appropriate treatment to be available is effective in ensuring a person receives clinically and psycho-socially effective help while being detained, and if not, how the criteria might be properly described
- Whether current risk thresholds under the Mental Health Act are the right ones, and if not, what they should be
- How the Mental Health Act can support positive risk taking and standardised/operationalised risk assessment when making decisions for detention and renewal of detention

The Group found that there are 4 key concerns about the criteria and process which found a decision to detain someone:

- **The current criteria for detention are vague**, and over-reliant on the simple presence of mental disorder, in a way which is discriminatory and inconsistent with developing international human rights standards. As a consequence, it is difficult to test or challenge the justification for detention. This can particularly be a problem when people are detained on the basis of a purported risk to self or others, at a renewal or appeal hearing: it can be difficult for a patient to demonstrate that they are no longer a risk.
- **The principles of respect for autonomy, reciprocity and least restrictive alternative are not upheld**, in that the patient's perspective may not be fully considered in justifying detention; and detention and forcible treatment can be authorised but the person may not receive the treatment and support which would allow them to recover, or live a meaningful life while on detention. We heard that the requirement for appropriate treatment to be available did not in practice always mean that treatment was either appropriate, or immediately available.

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- The provisions for **detention for treatment (s3) and detention for assessment (s2)** do not articulate well and are significantly different in the rights afforded patients. Professionals have differing views on which section is appropriate in often similar cases, but the use of s2 is growing and putting increasing pressure on the Tribunals Service (in 2016/17 s2 applications amounted to 30% of the English Tribunal's workload - up from 23% in 2009/10).
- The **time limits** for both short term and longer term detention and before automatic review by a Tribunal are too long, and increasingly out of step with international comparators.

The changes we propose would strengthen the rights of patients, make decisions on detention more transparent and ethically justifiable, encourage greater patient agency and promote more consistent and thorough care planning throughout the detention process.

2. Findings

We have three key recommendations

1. The detention stages and timelines should be reformed to make them shorter with similar benefits:

- a s2 type detention lasting up to 14 days, renewable for up to a further 14 days by both a responsible clinician and an AMHP,
- one right of appeal, to be listed within 7 days either during the first 14 day period or the second 14 day period, but not both
- a s3 type detention for up to 3 months, renewable for up to a further 3 months by both an RC and an AMHP, then recurring at 6 months intervals,
- the s3 type detention should require Tribunal consideration at no later than three months, again after a further three months, after a further 6 months and then annually
- it should not be possible for a person to be made subject to detention and then not admitted to hospital because of bed pressures, so a time limit for the order is proposed
- s117 aftercare should apply in the same way to both types of detention

2. The criteria for detention should reflect the ethical justification for detention. This includes requirements that:

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- because of mental disorder, the patient's ability to make decisions about the provision of medical treatment must be significantly impaired;
- there is a significant likelihood of imminent harm to the health, safety or welfare of the person, or the safety of any other person; and
- treatment is available which would benefit the patient, and which cannot be delivered without detention.

3. Detention should require a comprehensive care and treatment plan, which should evolve through the process from initial assessment to treatment and discharge. It should set out:

- the full range of treatment and support available to the patient from health and care organisations;
- any care which could be delivered without compulsory treatment;
- why the compulsory elements are needed;
- what is the least restrictive way in which the care could be delivered;
- any areas of unmet need; and
- how specifically the current and past wishes of the patient (and family carers, where appropriate) have informed the plan.

3. Rationale

Detention stages and timelines

We considered the proposition in the Interim Report that s2 and s3 be merged, and developed an initial proposal. Discussion in the group and at the mid-point review highlighted concerns among some stakeholders that merger might result in the increase in the maximum initial period of detention, which could be distressing for patients currently detained under s2 who are often discharged well before the 28-day deadline. There were also concerns that a merger may lead to unsustainable rises in the number of Tribunal hearings.

We concluded that there should be a process which delivers greater consistency and improved safeguards, without specifying how this would be legislated for. Key principles of our approach were:

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- There should be no detriment to the patient because of the way they entered the system
- Detention for longer should require greater certainty and a more robust care and treatment plan (CTP).

Emergency detention under s4 was not in our remit. However, consideration will need to be given to how the new detention criteria should operate in emergency situations.

In the majority of cases where detention is likely to be for a short period, or further assessment is needed, the initial period of detention should be no longer than 14 days (s2). During that period, the CTP should be developed. Before the end of the 14 day period, a decision should be made by the Responsible Clinician (RC) and an Approved Mental Health Practitioner (AMHP) as to whether the detention should continue. There would be two options – an extension of the assessment period (once only) for up to a further 14 days, or moving following re-assessment to a long-term s3 order.

The patient could apply to the Tribunal for discharge within the first 7 days of the s2 order. If the order is extended for up to a further 14 days, a similar right of appeal would apply within the first 7 days of the extension. However, only one appeal would be allowed within the overall 28-day period.

In some cases the patient may be known to services, and it would be possible to establish a sufficiently robust care and treatment plan without a full 14 day assessment period being required. In those cases, it should be possible to proceed directly to a long-term order.

An alternative, if our original plan for a merged process is preferred, is that everyone would be admitted on a 14-day order, and the long term order would follow, where justified.

The long-term order would be for up to three months, renewable for a further three months, and at six-monthly intervals thereafter. Renewals should be by the RC and an AMHP.

We propose that there must be a Tribunal hearing at the expiry of three months, if there has not been an appeal during that period. The same would apply if the order is renewed for a further three months, at the first anniversary of the order, and annually thereafter.

The rationale for including the AMHP in the renewal is that they will bring a broader perspective than a medical one on what alternative solutions might be available to avoid detention in the first place, and will be better placed to consider what other supports should be in place during detention, and how this might translate into a plan for aftercare.

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The right to aftercare is for another topic group to consider, but we believe it should apply in the same way to patients detained for 14 days as it would for patients on long-term orders.

Tribunal needed to authorise detention

Some of the group favour the Tribunal being required to authorise a long term order at the start, as in Scotland, believing that early judicial oversight provided better protection for the patient, assisted with ECHR compliance, and would ensure that the grounds for detention and the care and treatment plan were properly scrutinised. Others are concerned at the burden on the Tribunal and that this would change the Tribunal from a body which provides judicial oversight to the body which actually detains the patient. There was no consensus so we are not making this recommendation.

The criteria for detention

We believe it is essential that the ethical justification for detention is clearly reflected in detention criteria: to ensure compliance with human rights standards, encourage professionals to think clearly about what they are doing and apply the principles of the Act, and allow for proper testing and challenge of decisions. The current test relies too heavily on the presence of mental disorder and a generalised ground of necessity in the interests of health and safety of the protection of others.

1. Capacity and impaired decision making

The fundamental justification in mental health law for non-consensual treatment of an adult is not that the adult has a mental disorder – it is that the adult's mental disorder has seriously compromised their ability to make autonomous decisions about their own care. We therefore believe that this should be one of the necessary elements of the detention criteria.

We identified two ways this could be achieved – either by a capacity test on the lines of the Mental Capacity Act, or by a looser requirement for a significant impairment of decision-making ability, as in Scotland, the Republic of Ireland and Australia (Victoria).

The capacity test would mean treatment for mental disorder being dealt with in the same way as treatment for physical disorders, so would be non-discriminatory, and could be simpler for clinicians and judicial bodies to understand and apply. However, there are problems with it, and we heard concern that a capacity test may result in patients being detained but left untreated. Other concerns include:

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- The capacity test for medical treatment is about the ability to make a particular decision, whereas detention is a process over a period of time involving a series of decisions, so it is difficult to know what it is the person must be incapable of
- In many patients capacity may fluctuate rapidly, and it is impractical to move a person on and off detention or compulsory treatment as their condition temporarily improves or deteriorates
- Waiting for patients to completely lose capacity may militate against appropriate early intervention, for example in patients in the early stages of a manic episode with a known trajectory, or an eating disorder
- It may mean treatment cannot be given to a person known to be a serious risk to others because of a treatable mental condition

Some in the group felt that these problems could be overcome and a capacity test adopted. The majority concluded that those problems were too great for us to recommend the immediate adoption of a capacity test. But we believe that the longer-term aim should be convergence between incapacity and mental health law, and so would encourage further consideration of how this can be achieved and whether the problems identified could be overcome.

Meantime, we propose that one of the criteria should be that, **because of mental disorder, the patient's ability to make decisions about the provision of medical treatment must be significantly impaired.** (In relation to short term detention, the requirement would be that it is likely that this is the case.) The experience of Scotland is that this is a workable test which encourages clinicians and Tribunals to think carefully about the implications of the patient's condition.

It is important that the statutory test is accompanied by clear guidance in the Code of Practice and careful design of forms, so that the evidence of 'significantly impaired decision making' is not simply a generic assertion of 'lack of insight' but a clear articulation of the way in which the person's autonomy is compromised.

We believe that the same test should apply to forensic disposals under Part 3, although careful thought should be given to addressing the risk of a reduced use of these disposals by the courts, because of public safety concerns.

2. Risk

We were asked to consider whether 'current risk thresholds' are the right ones, how to support positive risk taking and 'standardised/operationalised risk assessment'. Risk is not explicitly mentioned in the current criteria for detention.

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We felt that, at the point of detention, there is usually good reason to be concerned about a person whose life is in crisis – the argument is less about risk levels than about what appropriate responses are available to support the person, and whether alternatives to detention are realistic. But once detained, it can be hard to demonstrate that the level of risk has reduced to an acceptable level, particularly if community supports for recovery are lacking.

We support an approach to risk which is informed by evidence and where the justification for imposed treatment is transparent and can be interrogated. However, we do not favour mandating particular risk assessment tools to give a 'score' for risk. These tools are of limited predictive value. Instead, we advocate a humane relational approach, where clinical and judicial decisions draw on a wide range of sources, crucially including the perspective and values of the patient, and where the potential harms of not detaining the patient are fairly balanced against the potential harms of detention and forced treatment.

We considered the introduction of a specific 'risk test', whether on the Scottish model of 'a significant risk of harm' or the more detailed test used in Ontario (risk of 'imminent and serious physical impairment of the person'). We concluded that the test should be reformed but that making 'risk' the key term could drive thinking too far towards a defensive and unbalanced approach to the balancing exercise.

Our proposed formulation is that one of the criteria for detention should be that **there is a significant likelihood of imminent harm to the health, safety or welfare of the person, or the safety of any other person.**

The Code and forms should require that practitioners demonstrate how they have assessed the potential benefits and harms of detention, other non-compulsory interventions which might mitigate risk, and how they have been informed by the voice of the patient. Our proposed care and treatment plan would support a dynamic, patient informed approach to risk.

3. Treatment is necessary and available

For detention to be justified, we believe that there must be **treatment available which would benefit the patient, and which cannot be delivered without detention.** That broadly reflects the current wording of s3, which we believe should also apply to short term (14+14 day) detention.

It should be made clear in the legislation or accompanying Codes that 'benefit', for the great majority of patients, would include contributing the patient's recovery and discharge, although we accept that slightly differing considerations apply, for example, in progressive conditions such as dementia.

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The group feel it is unacceptable to say that it is 'necessary' that a person be detained, and then not to make available the provision they need, but we found that there is evidence of this happening. The Act should ensure that it doesn't, and so as a starting point we are proposing a 4 day time limit (after which the order would lapse) as a possible solution, but we recognise that precise timeframes and consequences (eg report to the CQC) will need to be further developed.

Treatment should be broadly defined, including skilled nursing intervention, psychological therapy etc. In situations of crisis, it may be reasonable for the main element of treatment to be to provide a safe therapeutic environment. However, the reality is that many wards are far from therapeutic, and it is not enough that the person is literally being kept off the streets. Nor should continuing detention be justified for long periods simply on the basis of the provision of 'general nursing input and self-care planning', and an assertion that the 'ward routine' provides a therapeutic benefit.

We also believe the way sections 2-4 and section 13 interact in the current Act could be improved to make clearer the holistic and inter-professional nature of the assessment and decision to detain when other options have been properly discounted.

A new care and treatment plan

It is central to our recommendations that detention should be justified in the context of a comprehensive assessment of the needs and wishes of the patient, the options available to meet those needs, and the route to recovery. Therefore, we propose that a statutory care and treatment plan should be prepared at the point of detention, and should evolve at the various stages in the process. This should be the shared responsibility of the responsible clinician/recommending doctor and AMHP in consultation with other parties.

Where a person is detained for 14 days for assessment, the initial care and treatment plan may be brief, setting out the known needs and wishes of the patient, as far as they can be ascertained, the aims of the assessment and treatment during detention, and any proposed timescales before improvement may be hoped to be seen.

During the assessment period, the plan should be developed, so that by the time of a long-term order being imposed, there is a clear account of why detention is needed and what it seeks to achieve. The plan will continue to develop during detention and should be updated before renewals and appeals. Increasingly it will focus on how to support the ending of detention and the aftercare that should be in place on discharge.

The plan should be wide ranging, on the lines of the model in s62 of the Scottish Act. It should set out:

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- the full range of treatment and support available to the patient from health and care organisations;
- any care which could be delivered without compulsory treatment;
- why the compulsory elements are needed;
- what is the least restrictive way in which the care could be delivered;
- any areas of unmet need; and
- how specifically the current and past wishes of the patient (and family carers, where appropriate) have informed the plan.

The Tribunal would not amend the plan, but should consider whether the compulsory measures are justified in the wider context of the plan, and whether the plan is in fact being delivered.

We are conscious of the need to avoid undue burdens on professionals, particularly at times of crisis. Our proposals reflect the kind of good care planning which should happen anyway, and the provision for the plan to evolve would avoid an overly bureaucratic process during the initial intervention, when the full picture may not be clear.

4. Implementation of recommendations

All of the recommendations would require legislation, as all would be amending statutory functions discharged by relevant persons/bodies under the MHA 1983. Legislative changes would need to be accompanied by Code of Practice changes.

Central government will need to be involved, as will HM Courts and Tribunal Services (HMCTS) for the Tribunal Service and the judiciary.

Funding will be required to resource additional burdens on the Tribunals by shortening the lengths of detention and the periods before which a review must be heard. The new, shorter initial detention periods under s2 and s3 may increase the number of applications for discharge in the first few weeks, although it is possible that this will be offset if patients are reassured by the shorter timescales and less inclined to appeal. We also expect that Tribunal may need to recruit more panel members, and this will take time. The Ministry of Justice is not funded to cover these additional costs, and so this may need to be included in an application to the next Government Spending Round.

The recommendations made by the topic group are intimately connected to the work of several other groups, including consent to treatment, family and carer and aftercare

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groups. In particular, the length of periods of detention and the opportunities for review will depend significantly on what is proposed by the Tribunals and Renewals group, and the conclusions they come to concerning the level of workload to be imposed upon the Tribunal.

These recommendations would directly or indirectly impact upon Wales as well as they will have impacts upon both reserved (justice) and non-reserved (wider health) matters. There will need to be consideration with Welsh Government as to how implementation of these recommendations would impact upon the position in Wales, given the disconnect between the reservation of powers to Westminster in relation to justice and the responsibility for the funding of the implementation of those powers lying with the Welsh Government. Having a two-tier system for Tribunals depending upon physical location would be problematic, especially given the substantial number of patients placed by English commissioning bodies in Welsh psychiatric hospitals.

5. Evidence and analysis

International comparisons – the group paid particular attention to a comparison of mental health legislation in five developed countries.²³

Timescales can drive behaviour. Statistics obtained²⁴ from the English Tribunal Service show that

- Approximately 30% of people on a S2 make an application to the Tribunal
- From this sample week, most patients make an application in days 5 – 9. The numbers after day 14 are so small as these applications have to be considered separately by the Tribunal and granted only if reasonable reason to appeal after the deadline of day 14:

²³ https://www.cambridge.org/core/services/aop-cambridge-core/content/view/1043291DBE9B8D24480D738D47E1BAD6/S0790966717000489a.pdf/comparison_of_mental_health_legislation_in_five_developed_countries_a_narrative_review.pdf

²⁴ Taken from all receipts in June 2018

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Total applications: 202

Day 1-4 No. (%)	Day 5-9 No. (%)	Day 10-14 No. (%)	After day 14 No. (%)
65 (32.2%)	81 (40%)	51 (25.3%)	5 (2.5%)

- English Tribunals stats for 2016-2017 show that 2,200 73% of patients were discharged within 48 hours of a scheduled S2 Tribunal hearing.

NHS Digital have provided us with an average length of stay of 53.3 days. This is for s2 and s3 detentions together, and is only for stay in an individual hospital so includes people who have not been discharged but have been transferred to another hospital for continuing treatment and detention.

Risk:

- [Risk, Safety and Recovery; Jed Boardman and Glenn Robert](#)
- Use of risk assessment instruments to predict violence and antisocial behaviour in 73 samples involving 24827 people: systematic review and meta-analysis; Fazel et al

The group also considered New Directions (the Millan review in Scotland) and the Scottish Act, the Ontario legislation, the draft Oviedo convention, and the briefings from the Review's Human Rights and Equalities Group.

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Patient dignity and safety

Chair: Dr Amy Pollard, Founder and Director of the Mental Health Collective

Working Group Lead: Kate King, Service User

Secretariat: Jennifer Harris, DHSC

Membership:

- Alison Cobb, Policy Advisor, Mind
- Sophie Corlett, Director of External Relations, Mind
- Professor Paul Crawford, Health Humanities, University of Nottingham
- Anthony Deery, Clinical Lead for Mental Health & LD, NHS Improvement
- Dr Fredrik Johansson, Consultant Psychiatrist, Clinical Lead for Quality Improvement, Islington Crisis Resolution Team
- Seth Hunter, Project Manager, The Dragon Café
- Vicky Romback, Matron at MH inpatient, Glenbourne Unit, Livewell
- Natasha Sloman, Head of Hospital Inspection, Care and Quality Commission
- Sally Smith, Executive Director for Therapies, Tees, Esk & Wear Valleys NHS Foundation Trust

In addition to the core members, the topic group may bring in expert contributors for specific issues within the topic, or to test emerging findings:

- Will Johnstone, Policy Advisor, Rethink
- Darren Watts, Carer, MHA Review, Service User and Carer Group

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Terms of reference

Remit

The interim report said the review 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

The group will consider how current inequalities can be addressed in relation to the Mental Health Act, and any recommendations will consider the potential impact upon individuals identifying with protected characteristics under the Equality Act 2010. In particular, the review is seeking to address racial disparities, with a specific emphasis on people of African and Caribbean descent or heritage.

The purpose of this group is to identify potential recommendations the review could make, in relation to the above and to support the review's overarching goals (see below).

Timing and outputs

i. Meetings

The Patient Dignity and Safety topic group will meet on the following dates:

- Monday 9th July
- Monday 16th July
- Tuesday 17th July
- Tuesday 28th August
- Thursday 6th September

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ii. Review point

Gap analysis and any additional research requirements by 17th July.

Progress update to the review by 31st July 2018.

iii. Final report

The group will produce a short report to the review leadership by 14th September 2018, using the agreed format, setting out key findings for consideration by the Review as they prepare their final report and recommendations to government.

The topic group's work will be supplemented by additional engagement activity.

Interdependencies

- Patient autonomy – on matters of culture and culture change, patient empowerment (eg confidence to complain) and mechanisms to deliver this, role of advocacy
- Procedural safeguards: Tribunals – on complaints mechanisms or other opportunities to raise concerns
- Advocacy – on role of advocacy to support patients in raising concerns
- Principles – on potential principles that might support greater dignity and safety

Goals set out in the review's interim report

- 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

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- Reduced harm and improved safety for all
- Professionals better able to deliver their expertise

Report

1. Issue

While a person is detained under the MHA, the importance of how that person is treated is paramount.

We have heard examples of excellent care, where service users reported that they were treated with dignity and respect throughout their detention. But only 1/3 of respondents to our survey felt they were treated with dignity and respect and we have heard evidence from many more that supports this finding. There is huge variation across the mental health system but at worst patients report that the way they are treated by staff, the level of threat and violence on the ward, and even the furniture and sound environment are indistinguishable from being in prison.

Many report being traumatised or re-traumatised because of a period of detention. Restraint is a routine occurrence on many wards, despite guidance that this should be a last resort. Agenda reports that about 20% of women in mental health facilities, 17% of girls and 13% boys were restrained in one year (2014-5)²⁵ and 32 women dying after being restrained whilst detained under the MHA over a five-year period²⁶. Prone restraint is used disproportionately on women and girls and leads to significant trauma for those restrained and witnesses. Sexual safety incidents are also common, with 1,120 sexual incidents reported between April and June 2017²⁷ and the trauma this leads to lasts long after someone has left hospital. For both restraint and sexual safety, data collection is inconsistent.

The experience of BAME patients indicates that many wards and staff fail to address negative assumptions about the nature and degree of their illness or to expect equality of

²⁵ Agenda briefing on the use of restraint against women and girls, Agenda, Alliance for Women and Girls at Risk, 2017.

²⁶ Women in Crisis: How women and girls are being failed by the Mental Health Act, Agenda, Alliance for Women and Girls at Risk, 2018

²⁷ Sexual safety on mental health wards, Care Quality Commission, 2018.

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outcome. Often care and treatment does not consider patients' needs and strengths relating to their race, culture, identity, their place in communities and experience of discrimination. LGBTQ+ patients reported being stigmatised and not having their needs addressed. Patients who have experienced trauma (sexual abuse or violence), reported having their experience ignored and their needs unaddressed. This is particularly pertinent for parents separated from their children. People with medical conditions and disabled people reported not having their needs met. The failure to identify past experiences or present strengths and attributes, and over-reliance on hierarchical authority, leaves patients feeling silenced, disempowered, and significantly exacerbates trauma.

Overall, coercion, a focus on behavioural compliance, use of reward-based levers for access to leave or family contact, lack of empathy and compassion, impersonal physical environments, lack of privacy and feeling safe, reduced contact with the outside world and too few or too distant staff all lead to people's human rights being disregarded. A lack of understanding of patients as individuals, and their lives in the community, leads to lowered expectations of functioning and recovery, inappropriate care and a lack of person-centred activities and therapies. All these factors also contribute to involuntary institutionalisation which creates barriers to recovery.

Despite the existence of wards which have solved these problems and despite many of these themes being identified repeatedly by CQC MHA monitoring reports, poor practice persists. Others have slipped below the radar enabled by inadequate ward inspection criteria, low expectations of what constitutes good care, inconsistent day-to-day reporting and complex complaints processes that prevent patients from obtaining redress for what has happened to them. All of this has allowed everyone, from local ward staff to national system leaders to overlook or even normalise what goes on. This situation has a negative impact on the working experience and retention of staff who are trying to work well within poor ward environments, as well as with patients who have stayed on such wards.

The positive changes and outcomes we are trying to facilitate, and how we would measure success is stated below:

- We would measure success by an increased focus on dignity, therapeutic benefit and the importance of empowering patients and enabling them to flourish, throughout the Mental Health Act, the Code of Practice and the many guidelines which underpin provision across the mental health system. We would like to see the safety of patients improved through a focus on creating organisational and ward cultures that value and support patients and good staff, rather than ones that meet needs and problems with increased restriction, a reliance on hierarchy and an expectation of passivity in increasingly over-clinical institutionalised settings.

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- We would expect to see a more proactive and robust approach from the organisations involved in delivering, regulating, monitoring, improving and funding services towards improving the experience of detained patients and valuing the social and therapeutic responsibilities of wards.
- We would expect to see improvements reflected in a reduction in the number of incidents of restraint and seclusion, particularly of members of BAME communities and young women and girls, and a reduction in sexual safety incidents.
- We would expect to see improvements coming from our recommendations to be reflected in demonstrably better care and treatment, and fewer incidents of poor care, treatment, abuse and consequent trauma (as indicated in feedback from patients). These improvements would be accompanied by increasing evidence of genuine co-production, peer-led and community work.

2. Findings and recommendations

Recommendation 1: The Mental Health Act should specify humanity, dignity, empowerment and supporting people to flourish as principles and pillars to support changes in practice.

Recommendation 2: The mental health system must commit to improving ward experience through sufficiently experienced and appropriately trained staff.

2(a): NHS England should work with HEE to improve staff understanding of the Mental Health Act, particularly the Principles, the accompanying Code of Practice and rights of patients detained under the Act.

2(b): NHS England and HEE should promote a model of leadership based on reflective practice and co-production, which takes responsibility for ensuring wards are therapeutic and empowering.

2(c): NHS England, HEE, universities and governing bodies should require staff to be trained on how to achieve equality of outcomes for all patients. This should emphasise a relational approach which responds to the context of people's lives and addresses issues including physical health; equality and equity; adverse life experiences; trauma and discrimination.

2(d): Arm's length bodies, Trusts, Commissioners and Providers must ensure inclusion of people with appropriate lived experience in decision-making at every level across the mental health system. This should be integrated with co-production work, quality improvement programmes and partnerships with community and peer-led groups.

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2(e): Trusts, Commissioners and Providers must improve recruitment and retention of permanent staff with appropriate training and experience, appointed at the right grades and with ratios identified to ensure safety and allow a positive ward culture and the development of meaningful therapeutic relationships.

Recommendation 3: Trusts, Commissioners and Providers need to improve the social environments of wards, focusing on community, relationships and empowerment, to promote therapeutic benefit and minimise institutionalisation.

3(a): NHS England and NHS Improvement must continue to drive quality improvement initiatives across the mental health system, placing particular emphasis on achieving improved levels of recruitment and retention of effective and caring staff, peer-led and co-production based initiatives to improve ward culture and patient outcomes and learning from existing initiatives including those that are community-based or peer-led and initiatives, such as Star Wards, that provide ideas for small scale interventions.

3(b): Trusts, Commissioners and Providers must change coercive behavioural systems and restrictions that lead to loss of autonomy and foster involuntary institutionalisation.

3(c): Trusts, Commissioners and Providers must provide enough staff to enable permanent qualified staff to be fully involved with patients in meaningful therapeutic interactions and activities, to improve ward cultures and address power-imbalances and sexual safety issues. These elements should become a standard aspect of CQC inspections and regular monitoring.

3(d): We welcome the progress of the Mental Health Units (Use of Force) Bill and recommend that wards take active steps to create calm, responsive and enabling environments which reduce agitation, frustration and the use of physical restraint.

3(e): Additional effort should be taken by providers to end blanket restrictions, as identified by CQC, including practices such as blanket testing of people on return from leave. It should be compulsory to report any other restrictions and all personal restrictions must be recorded with accompanying reasons.

Recommendation 4: The mental health system needs to improve the physical environments of wards by:

4(a): Reviewing and updating physical requirements (building notes, regulatory standards) and expectations at CQC inspections and monitoring etc, so as to promote improvement of patient units, with a recognition of the fundamentally different requirements of a mental health unit to both those of the medical estate and those of the prison system; and with the express aim of providing therapeutic and responsive environments that maximise the homeliness of the unit.

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4(b): Mandating and funding, with a matter of urgency, improvements already identified and the subject of existing work by NHSI, CQC and (charities):

- Single sex accommodation,
- Environmental adaptations that provide safety from sexual (and physical) assault;
- Elimination of shared accommodation;

4(c): Creating environments that, along with provision of enough trained staff, provide:

- Wards that are acoustically and visually calm in use and which utilise furniture, fittings, soft furnishings and decoration that work against involuntary institutionalisation of patients and staff;
- Wards that are clean, functional, with reliable, appropriate temperature control and light levels, and with adaptations, when required, to provide equality of access and use for those with disabilities;
- More homely and less institutional settings by considering, when choosing specialist design, furniture, fixtures and fittings, the actual prevalence and severity of any problems that the features and improvements are designed to address alongside any potential negative consequences on patient experience, (eg feelings of entrapment or powerlessness, social isolation, increased noise levels, lack of comfort) and bearing in mind the primary importance of good quality staff/patient interactions and relational security in creating a safe and enabling ward;
- Free access to bedrooms, communal spaces, outside space and physical activity;
- Genuine access to areas that provide and encourage regular, informal and spontaneous activities and to those that allow for privacy, including for telephone calls, quiet spaces, visits and meetings;
- Resources that allow patient engagement in person-centred activities that promote and maintain independence and community and social links including creative, physical, social, musical, religious, work and daily living-related activities, and access to digital media and the internet;

4(d): Use of co-produced iterative methods (eg QI) involving, as equal parties, people who are and/or have been inpatients, and those representatives of the communities served, to identify problems and ongoing creative solutions relating to any of the above issues, addressing them through physical change, staff practice and/or other means.

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4(e): Trusts, Commissioners and Providers, in response to the above, providing evidence of monitoring and ongoing work to improve and maintain the physical environment of wards and units, including evidence of ongoing use of iterative co-produced improvement methods (eg QI) as well as engagement with external projects (eg community-led, design in other semi-public environments such as hospitality).

Recommendation 5: The mental health system needs to improve the provision and nature of person-focused care:

5(a): Review and update inspection and monitoring of individual treatment and care and promote ongoing improvement, with a recognition of the importance and multifaceted impact in mental health care of patient autonomy and a person-centred approach; improve collection and monitoring of patient experience particularly from those in secure and out-of-area placements.

5(b): Government bodies, Trusts, Commissioners and Providers must pursue ongoing work to:

- End inappropriate inpatient placements of people with ID and autism;
- Provide sufficient appropriate settings for children and young people and for mother and baby units to minimise displacement from home communities and separation of children from parents;
- End the use of inappropriate out-of-area rehabilitation placements;
- Address the widespread use of restraint and particularly prone restraint.

5(c): Trusts and Providers must ensure that wards:

- Consider and respect each person within the context of their own life and show an awareness that person's experience (including adverse life events, disability, discrimination and trauma), recognising that their identity and the community from which they come can all bestow particular strengths and vulnerabilities and can affect their experience of mental illness, mental distress, treatment and care;
- Have sufficient appropriately trained staff to enable patients to have a daily one-to-one with permanent staff and to receive, at the minimum, NICE approved psychological therapies on the ward;
- Tailor care and treatment to achieve equality of outcomes across the patient community regardless of any protected characteristics, and making any reasonable adjustments as required under the Equalities Act to ensure good care and treatment;

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- Respect a patient's social relationships and help the patient to maintain or rebuild those that they identify as helpful to their mental health and wellbeing;
- Respect a patient's place in their community, for example in school, places of study, employment and social and religious activity, and work with the patient to facilitate and maintain those connections and related activities.
- Value and support parenting, maximising and supporting contact between parents and dependent children, recognising and supporting those impacted by separation so as to mitigate the impact on those affected;
- Monitor and assess a patient's physical health, achieving timely recognition and treatment of any physical illness and condition; support the patient in management of ongoing conditions and facilitate and empower patients to maximise their potential for self-care and physical wellbeing;
- Offer patients the option of gender and culturally-appropriate professionals for treatment and care, particularly in the case of 1-to-1 observations.

Recommendation 6: The mental health system should work to improve **the complaints process** at every level, from arising day-to-day issues to more formal complaints taken to the CQC and the Ombudsman. This should be done alongside work to improve monitoring and learning from patient experience whilst under the Mental Health Act.

6(a): NHSI to amend its' good governance framework to include:

- That provider complaints teams receive MHA training, so they understand the added urgency and importance of complaints for those who are detained;
- That people with lived experience are involved in investigating complaints and serious incidents;
- That board papers disaggregate MHA complaints and complaints from informal patients;
- That lessons resulting from upheld complaints are recorded and published, with a requirement on providers to explain recurrence of issues raised in previous complaints;
- Patient representation for all board discussions about MHA complaints and this to become a part of CQC monitoring and inspection.

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6(b): Department of Health and Social Care to amend the Code of Practice for providers on complaints systems to ensure patients are fully informed of their rights and emphasise the higher level of urgency and importance of dealing with complaints made by or on behalf of patients detained under the Mental Health Act. This must be incorporated into CQC monitoring and inspection. Changes to the Code of Practice to include:

- Amend Section 132 to include making sure the detained patient is aware of their human rights (and qualified rights) under the 1998 Human Rights Act, and their right to complain without prejudice to their treatment;
- All MHA complaints be acknowledged within 48 hours, with the name of a person who will take responsibility for communicating with them about the case;
- All MHA complaints should consider and report whether bias or discrimination due to any protected characteristics of the patient has adversely affected a patient's treatment and care or expectation of treatment outcomes;
- That those making complaints be given a timescale within which they will receive a response to their complaint, be given regular updates on progress and informed on time limits for escalating complaints to the Ombudsman;
- That those making complaints be able to 'stop the clock' on a complaint while they deal with, for example, illness, trauma or bereavement;
- That investigation reports and recommendations produced by the CQC be put up in an easily accessible area of the Trusts website alongside relevant action taken by the Trust;
- That any delays in the complaints process, and any discovery of material errors in evidence, should be recorded along with an explanation of how and why they occurred.

6(c): The new Parliamentary Services Ombudsman, when it takes over Mental Health Act complaints from the CQC, to deal with complaints regarding the decision not to detain a person within the same team and with the same level of urgency as Mental Health Act complaints.

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6(d): Trusts and providers to ensure that:

- Information is made widely available about the opportunity to feedback and the right to complain and how to do this, and that this information be made available in accessible mediums;
- Patients who make complaints are never adversely affected in terms of their medication, ability to remain on wards, leave arrangements or treatment by staff and that any concerns raised about any such adverse effects are recorded and addressed urgently and separately from the main complaint;
- That staff and patients are encouraged to regularly discuss how the ward is run and patients to feed in views and concerns;
- Patients are regularly encouraged to give informal and formal feedback on their care and treatment and, where they raise concerns, they are proactively reminded of their right to make a complaint;
- Patients are proactively offered advocacy if they raise a concern;
- Patients and others making Mental Health Act complaints are treated with respect and all complaints are taken seriously;
- Staff abide by the duty of candour and are open about mistakes or failures and offer apologies speedily and sincerely where these are merited.

3. Rationale

As stated by a service user *“feeling supported and cared for in the first instance is the most important thing. Learning to have a voice that will be heard, to feel seen, has to come before therapy”*²⁸. Reports of poor patient experience²⁹, lack of safety and particularly traumatic experiences of patients detained under the Act, especially on wards, does however raise concerns over the current system. People’s human rights have been ignored and there is clear inequality in how failings in the system affect different groups. We have looked at the evidence of what leads to safer and more therapeutic experiences where we could find it and heard of many examples of positive changes. Across the

²⁸ Excerpt from service user submission emailed to Mental Health Act Review inbox – see Appendix A

²⁹ In addition to MHAR survey and engagement findings, published work echoes same findings: Chambers et al., The experiences of detained mental health service users: issues of dignity in care, BMC Medical Ethics (2014)

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evidence heard, it is apparent that a combination of an iterative 'needs-based' approach with supporting legislation and regulation is urgently required. We have hence developed recommendations which reflect this need for change and support the Review's goal in ensuring service users and carers are treated with dignity, respect and wellbeing, reducing harm, and improving safety for all through a 'needs-based' approach founded in human rights.

Our recommendations around improving ward environments, both in terms of physical and social aspects, stems from the examples of good practice from 'Outstanding' rated wards and other initiatives³⁰ and research conducted into therapeutic benefits of physical and social environments³¹. The specific need for improved services for women and girls, especially around sexual safety, comes from recently reported findings, from Agenda³² and the CQC³³, on how the mental health system is failing these groups. Our recommendations support those published in these reports. If implemented, these recommendations must help to improve patient experience and will likely reduce the need for lengthy detentions.

4. Implementation of recommendations

The recommendations from this topic group must be considered in conjunction with recommendations from the Principles; Police; Advocacy; Discharge and Aftercare topic groups and rely on both legislative and practical methods of implementation.

In welcoming the introduction of Principles on the face of the Act, the Mental Health Act 1983 will mandate practice which is humane, dignified and empowering. For this legislative change to have an impact practically, the Code of Practice should be altered in order to reflect the Principles and the depth of their meaning. In addition to altering the Code of Practice according to the new Principles, the Code of Practice should be revised to promote, ensure and maintain therapeutic social and physical environments (incl. acute and secure wards) for informal and detained patients. The Code of Practice must also reflect and acknowledge a 'needs-based' style of practice, to ensure all protected characteristics and cultural needs are met.

³⁰ Good practice examples include, Glenbourne Unit (Livewell, Plymouth); East London NHS Foundation Trust (London); The Dragon Café (London) and Gellinudd Recovery Centre – Hafal (Wales).

³¹ Research collated by MHPRU on therapeutic environments,

³² Women in Crisis: How women and girls are being failed by the Mental Health Act, Agenda, Alliance for Women and Girls at Risk, 2018

³³ Sexual safety on mental health wards, Care Quality Commission, 2018.

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To ensure these legislative changes result in improved practice, all staff using the Act, including non-hospital staff eg police officers or IMHAs, must be retrained on the Principles and new responsibilities under the Act. This should include training on unconscious bias, leadership, crisis management and diversity and cultural awareness. The topic group appreciates that similar training already exists but it must be delivered with 'needs-based practice' at the heart. In addition to staff training, quality improvement (QI) programmes, which have proven to be effective in improving patient experience, must be adopted across the mental health system. This will empower wards to deliver an iterative and personalised approach to ward improvement and ensure wards take responsibility for the experience and needs of patients on their wards. This implementation will require HEE and NHS England to financially support and establish these training programmes, and will require CCGs and Trusts to ensure retraining of their staff.

Further to legislation and retraining, CCGs, Trusts and CQC must implement improved systems for monitoring and inspection. There must be regular monitoring of complaints from patients pertaining to their ward experience or care and treatment, for which the responsibility lies mostly with ward and Trust management; there must be inspections occurring more regularly than once yearly, which involve patients views on their experiences, for which wards and Trusts can be rated against. Furthermore, CQC will have to adopt new inspection and monitoring framework which includes adherence to the Principles under the Act. Monitoring and inspection across the mental health system must be improved to prevent against wards providing non-therapeutic environments, Trusts dismissing complaints and serious incidents and the attitude of 'good behaviour only during inspections'.

Of these recommendations, the expected timescales for all are medium-to-long term and all require financial investment in staff training, estate and ward improvement, and quality improvement programmes. Specific costing analysis has not been achieved through this topic group process.

In terms of scale and scope, these recommendations represent an overarching set of fundamental changes which should be adopted nationwide across the mental health system. For wards and trusts which are already undergoing quality improvement programmes or already have an outstanding CQC rating, with co-production and a 'needs-based approach' at the heart, they are already compliant with our proposed changes. Regarding groups which should be considered in conjunction with these recommendations, the 'needs-based approach' underpinning these recommendations should be inclusive of all characteristics protected by the Equality Act, as well considering socio-economic and health inequalities (to include protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation). In particular, changes to practice must work to restrict the disproportionate use of physical restraint of female patients, and must promote the right to family life through ensuring parents or children detained under the Act

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are able to maintain contact with family and friends, with wards providing family-friendly spaces for visits.

When considering implementation of these recommendations, there are many challenges. First and foremost is the challenge of cultural change. Culture lies at the heart of many of the issues relating to how people are treated which cannot always be achieved through legislation. However, with Principles on the front of the Act and a new expectation from CQC, CCGs and Trusts to adopt an individualised approach to care and treatment across the mental health system, such changes may indeed succeed in setting the scene for removing stigma and promoting a positive culture around mental health. Furthermore, the power-dynamics that play out within wards are embedded in a wider social context of inequality and disadvantage, which means that patients do not arrive in hospital on a level playing field. The challenge of delivering every patient's human rights to achieve equality of outcomes, requires commitment not only across the health system, but far beyond it. Hence in order to implement, legislative changes in conjunction with practice reform and collaboration across services and organisations is required. NHS England, the CQC, CCGs and Trusts must collectively commit to delivering a therapeutic, 'needs-based' mental health system, that ensures every individual is treated with dignity in a manner which promotes recovery, management and empowerment.

5. Evidence and analysis

To understand service user and carer experience of the MHA, the group's membership represented service users, carers and people with protected characteristics. The topic group also drew on findings from the MHA Review's surveys³⁴, and submissions received from service users and carers³⁵, as well as service user and carer accounts from the Service User and Carer group, public engagement events and reports³⁶. Specific insight into patient experience of those from a BAME background was provided by membership and the Mental Health Act Review African and Caribbean group. Specific insight into patient experience of women and girls, particularly around restraint and sexual safety was provided by the CQC and published reports by Agenda and the Mental Health Foundation³⁷.

³⁴ Appendix B for excerpts from the Mental Health Act Review survey analysis by the Centre for Mental Health

³⁵ Appendix A for excerpts from service user and carer submissions received by the MHAR inbox.

³⁶ Women in Crisis: How women and girls are being failed by the Mental Health Act, Agenda, Alliance for Women and Girls at Risk, 2018; A Mental Health Act fit for tomorrow: An agenda for reform, Mental Health Alliance, 2017; Suffering in Silence, Healthwatch, 2014;

³⁷ Agenda briefing on the use of restraint against women and girls, Agenda, 2017, Women in Crisis: How women and girls are being failed by the MHA, Agenda, 2018, and While Your Back Was Turned, Mental Health Foundation, 2017.

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To assess what leads to safer and more therapeutic experiences, evidence from a range of sources has been used. Recommendations were informed by examples of good practice and community services, namely the East London Foundation Trust's quality improvement programme, the 'Outstanding' rated Glenbourne Unit, Livewell Southwest in Plymouth, The Dragon Cafe in London and the Gellinudd Recovery Centre in Wales run by organisation, Hafal. In addition, published research on compassionate care³⁸ and treatment and the role of therapeutic social and physical environments on mental health wards in patient experience and recovery were considered³⁹. Recommendations were further informed by annual CQC reports on Monitoring the Mental Health Act⁴⁰, briefing from the Human Rights topic group on patient dignity and safety, as well as membership from CQC and NHS Improvement to inform of current programmes of improvement across the mental health system.

Appendix A: Accounts of service user experience submitted to the MHA Review Inbox

The following excerpts are from submissions made voluntarily by service users and carers to the MHA Review inbox. The submissions were anonymised and any information relating to specific Trusts removed. The accounts and experiences of relevance to the remit of the Patient Dignity and Safety topic group were reviewed by topic group members, alongside other evidence sources, to understand the patient experience of being under the Act.

1) "If my lovely, now 20-year-old daughter had not been detained under the Mental Health Act she would most likely not be alive." – Family

2) "Feeling supported and cared for in the first instance is the most important thing. Learning to have a voice that will be heard, to feel seen, has to come before therapy..." – Service User

³⁸ Published research on compassionate care in the mental health system, references available in bibliography in Appendix C

³⁹ Research collated by MHPRU on therapeutic environments, references available in bibliography in Appendix C

⁴⁰ Monitoring the Mental Health Act 1983, 2010/2011 and 2016/2017, Care and Quality Commission.

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3) "My own life has been devastated by mental ill health...my clinicians have commented on my excellent progress, in part down to the holistic care in hospital and also down to my determination to achieve both clinical and personal recovery..." – Service User

4) "One of my lasting impressions of the mental health act as a patient is how I came to view it as a very negative tool used by staff to manipulate and control me into adhering to care plans that I had no efficacy over; staff from all disciplines in my experience often used The Mental Health Act as a threat...Personally, I would like to see am mental health act that was much more focused on sustaining recovery and building strengths. I think the challenge for the review committee is finding where it can install Hope, Control and Opportunity to an Act that is designed to install the exact opposite." – Service User

5) "Some procedures of the Mental Health system referring to sectioning and any stark psychiatry is not a remedy and has negative results and should only in my opinion be short term control for extreme cases...The system of stark Psychiatric sectioning and is at risk of breaching the aspects of humanity..." – Service User

6) "I have made a complaint to the Ombudsman. Two of the complaints I feel are legitimate repeatedly asking, sending letters to Hospital, psychiatrists, ward nurses for scientific evidence that psychosis is caused by a chemical imbalance, serving thirds of dinners to people who are on medication that make takers of the drug search for carbohydrates and who are already obese. Their reply was that they could not deal with the complaint because it fell under the Metal Health Act and signposted me to the CQC, who said they couldn't deal with it and sent me back to the Ombudsman, who didn't reply to my further emails. This is not an advocate but it shows the type of difficulties you have if you want to complain about something. There is no body outside the Government or without Government funding to appeal to." – Service User

7) "Staff in mental health units either sit behind glass or in an open ward...Support is gained from other patients." – Service User

8) "From my experience the risk adverse nature of acute mental health units sadly means that many good things are taken away from you whether they are a risk to you personally or not. Due to risk, I rarely was able to do my embroidery, I often didn't go out for a walk because it was not facilitated, I found myself in a chaotic environment that was not therapeutic at all and where I was exploited both financially and sexually, I didn't even have access to hot water which meant I couldn't have a decent cup of tea...In addition the lack of positive creativity on acute wards meant that I became more creative destructively, and my self-harmed and suicide attempts became more extreme..." – Service User

9) "I think it important for there to be a principle of reciprocity. Ie. clinical and non-clinical staff needs to be treated with dignity and respect also...Perhaps such a principle could be in a new code of practice?" – MH professional

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10) "I am pleading with you to review the fact that one psychiatrist has all the power, especially when we are talking about power-hungry individuals, with threats made and no ounce of compassion displayed during communications. Appointments to see the responsible clinician are sparse and time is always limited - he is always in a hurry. It always felt rushed and very stressful indeed...I made umpteen calls to the Care Quality Commission, as [my doctor] persistently made my life a living hell." – Service User

11) "...nobody wants to hear me...Feeling supported and cared for in the first instance is the most important thing. Learning to have a voice that will be heard, to feel seen, has to come before therapy." – Service User

12) "Provide good environments for social interaction in the community to encourage socialisation and well-being, such as community cafe, walking/sporting/recreational events to make friends and encourage mutually beneficial socially orientated creativity." – Service User

13) "Well ventilated, freshly aired accommodation, nutritionist supervised wholesome diet, exercise outdoors and indoors if requested or suitably beneficial for the patient etc." – Service User

14) "...the solitary confinement, the lack of respect, autonomy, care, decent brain supporting food and compassion, it is all a crime, a crime against humanity!" – Anon.

15) "...people need fresh air natural and normal surroundings and hopefully are able to continue with a healthy lifestyle, balanced routines and privacy." – Anon.

16) "If the Mental Health Act gave more power to patients to lobby statutory organisations such as housing authorities, clinical commissioning groups and mental health service providers to give them the care and interventions that they needed to sustain their lives in the communities I believe we could see a huge reduction in the overall number of revolving door clients." – Service User

17) "With regard to BME patients, I think lack of cultural awareness among mental health staff and is a major issue." – Service User

Appendix B: Evidence from the Mental Health Act Independent Review survey

The following are excerpts from the draft survey report (July 2018) produced by the Centre for Mental Health (CMH). These excerpts supported the discussions around identifying issues and recommendations.

a) Appropriateness of inpatient settings

This theme concerned how the inpatient setting in which a person was placed was not designed around a particular group's needs, including that of:

- Women (and a desire for a choice over single sex wards);
- People with autistic spectrum disorders (sometimes related to staff having little apparent knowledge of these conditions);
- Children placed on adult wards (relating to safeguarding and lack of peers).

b) Experience themes

i) Treated with dignity and respect?

- Both those with lived experience and carers were asked if they were treated with dignity and respect. A number of experience themes emerged from these two questions:

“...During my first experience of being sectioned I was treated with no dignity or respect and will never recover from that terrifying, degrading experience...” (LEX1178)

- Many people had a mixed experience. Some periods in hospital under section were more positive than others, and others found that this varied depending on the staff who were there with them on a particular day.

“...Sometimes, maybe even most of the time. This was too dependent on an individual staff member's personal feelings, though. Some would make an action that was supposed to be keeping me safe feel very intrusive, whilst others showed more understanding of the loss of dignity that comes with being closely monitored 24 hours a day...” (LEX1215)

“...there are some amazing people working in mental health but there are also quite a few that really shouldn't be! So yes and no depending who was looking after me...” (LEX1248)

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“...Yes, even though I was told to give my phone, clothes ...to the nurses it was all explained to me the reason why. They were respectful to me and very empathetic and they were also caring and made sure I had something to eat and that I was as calm as I could be...” (LEX1496)

Quite a number of people with lived experience were positive about how their carers had been treated.

“...Yes, when visiting, they had good and welcoming treatment from staff and patients...” (LEX496)

“...They were, yes. They were eventually notified of my whereabouts and they were then kept in the loop...” (LEX576)

- But a “yes” was not always a ringing endorsement and some of those with lived experience felt their carers had a mixed experience.

“...Yes on the first occasion and they were blatantly lied to on the second...” (LEX880)

- There were several comments to the following effect:

“...Yes, more so than me...” (LEX1280)

ii) Use of restraint

- There was concern over the use of restraint (in the region of 80 people with lived experience mentioned being restrained) and accounts that described what could have been serious assaults carried out by staff on patients. These included accounts of limbs being broken. There were accounts of restraint where the person with lived experience felt excessive force had been used.

“...I was held down and injected and although I needed it I ended up covered in bruises. They could have been more gentle. Also I was kept in de-escalation and after saying I needed the toilet they wouldn't let me. I couldn't hold it in and ended up going in a plastic cup. That never should have happened...” (LEX1438)

“...Being restrained by 5 men and taken into a fellow patient's bedroom, thrown on to a bed. Having my skirt pulled up, underwear pulled down and injected with heavy tranquilisers is not care...” (LEX483)

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Appendix C: Bibliography

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Advocacy

Chair: Kathy Roberts, Chief Executive, Association of Mental Health Providers

Working group leads: Danielle Hamm, Associate Director, Campaigns and Policy, Rethink Mental Illness; Alex Kennedy, Head of Campaigns and Public Affairs, Rethink Mental Illness

Secretariat: Graham Sale, DHSC

Membership

- Joe Bowerbank, Wiltshire Council
- Neil Brimblecombe, London South Bank University
- Marie Casey, SEAP Advocacy
- Jacqui Dyer, Mental Health Act Review African and Caribbean group (MHARAC)
- Steph de la Haye, advocate, trainer and service user
- Karen Newbigging, University of Birmingham
- Roger Talbot, Service User and Carer Group
- Richard Walsh, Rethink Mental Illness

In addition to the core members, the group may bring in expert contributors for specific issues within the topic, or to test emerging findings.

Terms of reference

Remit

The interim report said the review 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.

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- 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.

The group will consider how current inequalities can be addressed in relation to the Mental Health Act, and any recommendations will consider the potential impact upon individuals identifying with protected characteristics under the Equality Act 2010. In particular, the review is seeking to address racial disparities, with a specific emphasis on people of African and Caribbean descent or heritage.

The purpose of this group is to identify potential recommendations the review could make, in relation to the above and to support the review's overarching goals (see below).

Nothing is ruled in or out, except that we have already established that advocacy is important and could be used more powerfully than it is currently.

To explore: Advocacy in Wales: voluntary patients qualify for an IMHA; advocacy in Scotland: community patients qualify for advocacy.

Timing and outputs

The group will meet formally three times in addition to engagement with a range of stakeholders.

i. Review point

Additional research requirements will have been identified and commissioned ahead of the midpoint (31 July 2018).

A progress update will be submitted to the review by 20 July 2018.

ii. Final report

The group will define an improved advocacy model(s) in the context of the current system, and will make clear recommendations as to how the revised model can be operationalised.

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The group will produce a short report to the review leadership by 14 September 2018, using the agreed format, setting out key findings for consideration by the review as they prepare their final report and recommendations to government.

The topic group's work will be supplemented by additional engagement activity.

Interdependencies

- Patient autonomy: what role can advocates play in increasing patients' say in decision-making, or their autonomy during a period of compulsion? An expanded remit would feature in both groups.
- Patient dignity: what role can advocates play in improving the patient voice and autonomy generally? An expanded remit would feature in both groups.
- Nearest relatives: how do IMHAs sit alongside a reformed Nearest Relative?
- Procedural safeguards: what role could advocacy play within different procedural safeguards?
- Care planning: what role can advocates play in assessment and care planning?
- Black, Asian and minority ethnicities: what is the BAME experience of advocates and how can this be improved?
- Community Treatment Orders: what role can advocates play in increasing patients' autonomy during a period of compulsion?
- Learning disability and autism: what is the LD/autism experience of advocates and how can this be improved?

Goals set out in the review's interim report

- 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

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- 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

Report

Background

The 2007 amendments to the Mental Health Act (MHA) introduced the new safeguard of an Independent Mental Health Advocate (IMHA). It came into effect in April 2009 in England. The MHA describes the IMHA role in terms of providing support to the patient to ensure that the patient has the information about, and understands the details of, their detention, the treatment proposed and how to exercise their rights under detention. It is an important safeguard for people who are in a very vulnerable position having basic rights removed.

However, as raised in the Review's interim report, a number of key issues surrounding IMHA provision are apparent.

1. Improving access

Issue

If people do not have access to IMHA services they are missing a basic safeguard – to which they are entitled. As well as compromising their ability to know and exercise their rights under the MHA, it can have knock-on consequences as to whether people exercise other rights, such as their Article 8 rights under the European Convention on Human Rights (ECHR) including contact with family and friends.

CQC's Monitoring the MHA in 2015/16 found that for 12% of patients interviewed on visits there was no evidence that they were informed of their right to an IMHA. This is clearly unacceptable and can be considered a breach of human rights.

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Recommendations

Recommendation 1a: Make advocacy opt out for all who have a statutory right to it, learning lessons from existing best practice including outreach models.

Recommendation 1b: Deliver enhanced training for trust staff on the role of advocacy and its importance in relation to patients detained under the MHA. This could be incorporated into existing MHA training, with advocates themselves involved in delivery.

Recommendation 1c: Mandate the CQC to have a consistent role in monitoring access to IMHA services moving forward.

Rationale

The Right to Be Heard⁴¹, a 2012 UCLAN report reviewing IMHA services in England, raised concerns regarding take up of, and access to, IMHA services. It concluded that access is influenced by availability of IMHA service, thus reflecting the variable quality of commissioning and the understanding of service users, as well as the attitude and understanding of mental health professionals to advocacy. The report recommended considering making IMHA opt out rather than opt in, with all qualifying patients getting the service of an IMHA unless they refused it.

It is important that the decision to opt out is taken by the individual, and not somebody on their behalf – and that decisions to opt out of advocacy provision should be checked at regular intervals. It was suggested that the need for timely reminders could possibly be linked to s.132 which outlines that people should be offered information and followed up.

Small-scale consultation with a number of providers already operating an enhanced opt in model – see Annex 1 for summary of questionnaire responses – made clear that current best practice models of outreach to staff, and regular, visible presence on wards, should be encouraged to implement an opt out approach effectively. The operationalisation of an enhanced opt out model in non-hospital settings, eg for individuals on Community Treatment Orders (CTOs), or in prison, requires further consideration.

Staff appreciation of the role of advocacy is central to effective operationalisation in any setting, however. This is pivotal in relation to access, and is therefore a central part of any successful opt out model. Small scale consultation with trusts revealed minimal existing training on IMHAs for staff, with only limited evidence of existing MHA training providing

⁴¹ The Right to Be Heard, Review of Independent Mental Health Advocate (IMHA) Services in England

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any relevant material on the role or benefits of advocacy. The delivery of additional training could benefit from enhanced involvement of advocates themselves, in doing so building relationships to ensure successful collaboration. Further, staff themselves could benefit from the development of knowledge and skills in relation to advocacy, which can helpfully be employed throughout the delivery of services.

In order to ensure increased access to IMHAs through an opt out approach, regular monitoring will need to take place at a local level. We suggest that the CQC should inspect access to IMHA provision as part of regular hospital inspections, recording and publishing numbers of patients accessing IMHA services compared to the inpatient population. This has precedent as part of former CQC reports on implementation of the MHA eg 2011/12 and 2015/16.

Evidence and analysis

As outlined above, a body of academic evidence puts forward a strong argument in favour of an opt out approach to improve access to IMHA provision. This primarily includes the findings of the Right to Be Heard report.

In addition, responses to the Review's call for evidence were largely in support of expanding access to IMHAs to improve recovery – which included responses from professionals and organisations who work in collaboration with advocates.

Further, despite the existing obligation for patients on a CTO or subject to guardianship to have access to IMHAs in existing legislation, certain organisations called for the review to reiterate the right to advocacy for patients on a CTO. This is due to gaps in provision caused by current models of provision, which is largely reliant on hospital environments and fails to reach effectively into the community. If we know that there is a problem with people on CTOs not getting the access to advocacy that they should, then arguably it should be opt out for them too – though what that would mean in a non-hospital setting would have to be developed.

The group therefore endorse the recommendation by the CTO group to ensure more consistent access to appropriate advocacy (IMHA) provision in the community, in line with the broadened scope of the role outlined at 3 below. This may require an expansion of what is considered 'opt out best practice', as the models that we were informed of focussed on inpatients.

Service users and carers who responded to the review's survey frequently cited the right to access advocacy as paramount, such as:

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“...I think that everyone going through a section should be afforded an independent advocate (mandatory), like having your own counsel when going through court...”
(CAR234)

Implementation considerations, including costs

The roll out of an opt out approach to IMHA provision will ultimately involve revisions to the MHA Code of Practice and related guidance in terms of best practice approaches for commissioning of services – it may also require amendments to primary legislation, but this requires further investigation.

Best practice models (enhanced opt in – as per examples at Annex 1) are possible within the current legislative framework but are not required. Contracts between LAs and providers more generally will need to take account sufficiently of the potential for additional calls on IMHAs’ time and associated outreach activities central to an opt out approach. Agreeing a standard set of guidelines to assist commissioners in drafting appropriate contracts will require consultation. Further work with the Ministry of Housing, Communities & Local Government and local authority (LA) representatives (eg Local Government Association) will be necessary to agree the scope of any guidance.

The consequences of changing from an opt in to an opt out model should have limited cost implications for commissioners given providers are currently contracted to provide services to the total detained population. Advocacy providers are currently likely to be making assumptions regarding demand, however, and any increase resulting from an opt out model may impact unexpectedly on workforce forecasting. This needs to be checked with LA representative bodies and commissioners.

Further, there is a possibility that other recommendations across the review to confer new rights on people being detained under the MHA could lead to increased work for safeguard mechanisms such as tribunals and SOADs. An advantage of advocacy services that are present and well-resourced on wards is that they will give patients a greater understanding of their rights and how to exercise them at an early stage without needing to escalate matters to more formal and more expensive safeguards unnecessarily. Similarly, this provides opportunity for advocate involvement in awareness-raising/training for trust staff.

We envisage broad support for greater access to advocacy from professionals and service users/carers alike, with the only potential issue of challenge concerning LAs in terms of resourcing.

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2. Widening eligibility

Issue

Current eligibility for IMHA services, as set out in the Code of Practice, is limited to the following patients:

- detained under the Act
- liable to be detained under the Act, even if not actually detained. This has a specific meaning, including those who are currently on leave of absence from hospital or absent without leave, but does not include voluntary inpatients
- those for whom an application or court order for admission has been completed
- conditionally discharged restricted patients
- those subject to guardianship
- patients subject to CTOs.

The role of advocacy has been argued to have benefit for other groups of patients, including those in hospital but not detained (informal patients) – as well as playing a role in preventing readmission to hospital following discharge.

Recommendations

Recommendation 2a: Extend the full statutory right to an IMHA to all inpatients in mental health hospitals.

Recommendation 2b: Extend the right to IMHA advocacy to those who have been discharged under the MHA and eligible for s.117 aftercare, if this is to be universal and time limited.

If the Review agrees with recommendation 2a above, as well as the emerging recommendation from the s.117 and aftercare group for all inpatients to be eligible for an intensive discharge plan, then IMHA provision would be available to all former inpatients upon discharge. However, the merits of this recommendation should be considered irrespective of potential crossover.

Recommendation 2c: Substantially increase availability of peer and/or community advocacy to support individuals in need of mental health support in the community.

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Recommendation 2d: Undertake further research and piloting to identify what value advocacy can have at assessment, eg where there are fully staffed and centralised places of safety.

Rationale

Extending the statutory right to IMHAs to all inpatients would address the issue of de facto detention and align with rights in Wales under the Mental Health Measure. Safeguarding people who are at risk of having their rights overlooked (such as informal inpatients) is paramount, and this argument is in accordance with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and the Equality Act which promote a right to a voice – particularly when in a voice-limiting situation such as being detained under the MHA.

In 2013 the House of Commons Health Select Committee conducted post legislative scrutiny for the changes to the MHA that had been made in 2007. On the Health Committee's proposal to extend IMHA eligibility to inpatients, the Government claimed that IMHAs are inappropriate for informal inpatients because they are defined in relation to the MHA, which by definition does not apply to informal patients. It suggested Care Act advocacy as an alternative, while noting that patients may not be eligible.

This argument is misguided for two reasons:

1. All of the legal and moral issues around the status of informal patients are clear evidence that knowledge of the MHA is not 'surplus to requirements'. Informal patients may be de facto detained and will want/need to know how their rights and safeguards differ under the two legal regimes. IMHAs are the only advocates qualified to provide this.
2. In addition to this important knowledge of the Mental Health Act, the specialist, non-legal knowledge of IMHAs of working with people in inpatient mental health units (for example, an understanding of conditions and care pathways) makes them by far the most appropriate type of existing advocacy for informal inpatients.

Although the Code of Practice states that IMHA does not replace other types of advocacy and works alongside other services, anecdotally it seems that the only advocacy services guaranteed to be commissioned are statutory roles ie IMHA, Independent Mental Capacity Advocate (IMCA) & Care Act advocacy. This is a major gap because non-statutory mental health advocacy can support someone with aspects of their life such as benefits and housing that contribute to their poor mental health. As such, extending the statutory right to IMHAs for those patients eligible for s.117 provision upon discharge will result in continuity of support during transition from institutionalised care into the community – and as such potentially reduce the likelihood of readmission. This recommendation is linked to the recommendation that IMHAs should have a role in advocating around care plans – with

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the result that advocacy, like the care plans, would follow people from within hospital to the community. In addition, entitlement to s.117 is a qualified right under the MHA, retaining the link between IMHA advocacy entitlement and being subject to the act.

Whilst particular groups may benefit from IMHAs in the community (ie before admission), a better approach is to make community support more effective. Although a causal link proving the ability for community advocacy to support a reduction in detentions is lacking, evidence does exist to support the benefit of peer-support approaches in relation to reduced readmission rates and overall service user experience. Furthermore, advocacy programmes which focus on the involvement of experts by experience (eg the ongoing volunteer advocacy programme at Springfield University Hospital in Wandsworth) are becoming more common, with positive feedback around the role and understanding of an individual with personal experience of mental illness – as well as the ability to facilitate links with communities and third sector organisations. Potential models of support in the community (ranging from peer groups to phone support) were considered, but no firm recommendations made on a preferred option.

Although it is assumed that an advocate could improve the experience and outcomes of an assessment under the MHA as supported by feedback from service users and carers through the survey, not enough is known about the potential for an advocate to reduce detentions if involved at assessment stage. No formal research has been identified to suggest a causal link between the presence of an advocate (IMHA or otherwise) and the likelihood of detention. There are also concerns about practical difficulties of getting an advocate to the assessment, and what this would mean in terms of potential delays, and of how meaningful advocacy can be at that point.

As such, further research to determine the effect of advocacy at the assessment stage should be undertaken. For example, a pilot of IMHA presence to align with ongoing s.136 places of safety pilots in London could be helpful in determining the perceived benefits.

It should be noted that the position of the African and Caribbean, and Asian and Minority Ethnicities, groups takes a stronger stance on the need for appropriate advocacy at the point of assessment – particularly in addressing underlying bias in the decision-making process, as well as the often-greater needs of individuals from certain ethnic backgrounds depending upon the setting in which any initial interaction with services takes place eg police. Whilst earlier support in community (eg peer support) is welcome, this is something distinct and vital. It is a role that should not necessarily be undertaken by an IMHA, and could helpfully be referred to as something distinct.

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Evidence and analysis

Patient advocate organisations responded to the review's call for evidence largely in favour of expanding IMHA provision to informal patients.

Service users and carers who responded to the review's survey were generally in support of widened eligibility for advocacy throughout the detention process, with a preference for involvement of an advocacy at the assessment stage:

"...Rights to an advocate at assessment time..." (CAR56)

"...They should have the right to an advocate at the beginning of their Section if there is no competent relative who knows how the system works. They should also have the right to be able to access legal information (through an advocate if necessary) so that they are aware of their rights...It isn't enough to tell them they are incarcerated for a certain period without knowing what that means. My experience is that patients often think they won't be able to leave or will be in hospital for far longer than they will actually be there..." (CAR1001)

Implementation considerations, including costing

Legislative revision will be necessary to expand the remit of current IMHA provision to cover all inpatients, regardless of formal or informal status, and those who have been discharged under the Act with s.117. The practicalities of legislative change mean that this is unlikely to be achieved in the short term.

Furthermore, the cost and resourcing ramifications of increased eligibility (and access) to IMHAs will mean that advance notice of implementation will be necessary to ensure a sufficient scaling up period during which active recruitment and training can be undertaken. This will require consultation with current advocacy providers and LAs to ensure realistic modelling of the potential pipeline.

Costing work is underway to model for a number of scenarios; however, a major limitation is the availability of national data on advocates. Therefore, our assumptions are likely to be based on regional level data which can be scaled up to achieve a national estimate.

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3. Broadening the IMHA role

Issue

The IMHA role as set out in the Act is not an exhaustive list, but anecdotal evidence suggests that in some cases the limited resources of commissioned services mean that only the aspects specified in law are being delivered – ie helping the individual obtain information about and exercising their rights under the Act. While advocates will often give broader support, we believe there is a strong case for a specific amendment to give advocates a formal role in supporting patients to engage in care planning, especially if the Review recommends a new statutory right to a care plan.

Recommendations

Recommendation 3a: Revise the statutory definition of IMHA advocacy to cover advocacy around care planning and advance statements (both of which are being strengthened elsewhere in the review).

- Also make clear that IMHAs should advise voluntary inpatients on the comparative rights/safeguards for voluntary vs detained patients.

Recommendation 3b: Recommend strengthening commissioning guidelines to make a clear presumption that IMHAs are best placed to provide support to MH inpatients in cases where there is an overlap with Care Act / Complaints / MCA advocacy, and should be resourced accordingly.

Rationale

The IMHA role should be reframed, shifting from a narrow conception of statutory advocacy as safeguarding rights to one emphasising self-determination and participation in decisions about care and treatment. This could include specifying a fuller range of functions in legislation

The recommendation to amend the statutory role of IMHAs should be seen in the context of the increase in patient involvement across the reforms being discussed across the Review: if patients are to have a greater say in their own care then it is right that they should have advocacy provision that supports this. While the provisions of s.130B are broad enough to cover advocacy around most specific new rights that are under consideration, we believe that there would be particular value in clarifying the role of advocates in relation to care planning.

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People have a range of needs and may qualify for different forms of statutory advocacy (IMHA, IMCA and Care Act). This can lead to complexities and fragmentation in provision, with individuals dealing with different advocates. Consolidation or streamlining of different advocacy provisions was consulted on in the Law Commission consultation on mental capacity and deprivation of liberty. A majority agreed with streamlining Care Act advocacy and IMCA; the consultation asked whether IMHA should be replaced by Care Act advocacy but there was no overall majority view and it was seen by some as too specialist to be consolidated.

In line with the interim report, the group considered streamlining different advocacy frameworks to introduce a simpler and more consistent approach. While advocacy provision across the health and social care, goes beyond the remit of the Review, we did consider this question from the perspective of those detained under the MHA or at risk of being so.

We undertook a mapping of the different types of advocacy, their roles and responsibilities and any training requirements – see Annex 2. There is frequent interplay across different types of advocates, with people often qualifying for more than one type which makes it difficult for commissioners and providers to decide which is most appropriate.

We heard evidence that the specialised knowledge and skills of IMHAs are vital and, if anything, should be developed further. Therefore, rather than moving towards merging advocacy provision, our preferred option is to make clear that IMHAs are most appropriate for all inpatients in mental health settings and those discharged under s.117. In line with the recommendations of the UNCRPD, the role of IMHAs to provide a voice and facilitate supported decision-making should be enhanced in favour of substituted decision-making models. This would need strengthened commissioning guidelines to support it – particularly in cases where there is overlap with other advocacy provision under existing legislation.

Evidence and analysis

Academic research has made the case for a broadening the IMHA role to promote participation in decisions about care/treatment.

Implementation considerations

Again, changes to the statutory role of an IMHA to include care planning and support for advance statements will require minor amendments to existing legislation – given the current role of an IMHA is set out in the MHA. An example of how this might be undertaken is attached at Annex 3. This will then need to be mirrored in the Code of Practice and relevant guidance.

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Such a shift in the IMHA role will require consultation with advocacy providers and consideration of existing training requirements. LAs will also need to be aware of the revised legislation against which they are contracting provision, and be assured of adequate levels of delivery (as per section below).

This links in with the potential revision of existing guidelines to 'demystify' the process of commissioning IMHA services, making clear the situations in which IMHA services should be commissioned (and provided) as opposed to other statutory provisions.

4. Revising IMHA training and standards

Issue

Variability in the quality of IMHA services has been a strong theme throughout the Review's engagement to date. Even when patients are successful in accessing IMHA services, disparities in quality and approach are evident across different areas and providers. Given the centrality of the IMHA role to provide a voice and explain rights to patients, poor quality provision can have a significant impact on patient experience and lead to detrimental outcomes.

Moreover, there is currently no standardised regulation of IMHA provision – relying heavily on advocacy providers themselves to undertake self-assessments. Oversight is managed by the commissioners directly, and therefore variable in approach.

Recommendations

Recommendation 4a: Retain existing IMHA training requirements, with some changes to the curriculum, and improve oversight of providers.

Recommendation 4b: Strengthen existing reports from advocacy providers to commissioners by incorporating input from trust staff, families/carers and clients.

Recommendation 4c: Recommend that the current Quality Performance Mark (QPM) is mandatory for all advocacy providers and that services are commissioned on the basis of QPM status. Implementation may necessitate a role for a national oversight body to monitor advocacy providers.

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Rationale

The current City and Guilds training package for IMHAs was originally devised to focus on the extra skills necessary for IMHAs beyond those built up through community advocacy provision. Nevertheless, a number of refinements could be made to ensure greater consistency in the training (and thus quality) of IMHAs and in doing so address variability of quality and many IMHAs' lack of knowledge of the MHA. For example:

- The current additional module on MHA legislation should be made compulsory.
 - This would respond to criticism of IMHA services not having a good enough understanding of the MHA legislation to advise patients appropriately on their rights.
- Basic modules on underpinning principles of advocacy should be made compulsory and improved to include focus on rights and power:
 - Given many new IMHAs do not have prior experience in community advocacy provision, it is important to ensure the basics of advocacy are taught and understood.
 - Furthermore, the ability of advocates to challenge, an often dominant, view of the medical workforce is a skill which should be emphasised, and is of particular importance for vulnerable groups.
- Training should include a placement, to allow people to see families/communities in non-ward settings.

The vital split between commissioning and delivery at the centre of advocacy provision is important to promote the independence of advocacy services, but necessarily raises challenges for feedback on quality of services (both advocacy and healthcare – see 5 below). Advocacy providers currently regulate the quality of the service themselves, which is insufficient. Reports on numbers and complaints are sent to LA commissioners – but could helpfully include wider input, particularly from staff working alongside advocates and family/carers, as well as from clients. In addition, current reporting is unlikely to delineate between IMHA provision and other forms of advocacy because of contracting preferences – this should be updated to ensure full understanding of IMHA provision.

Anecdotally, spot purchasing has driven down the quality of services and as LAs commission fewer and fewer hours, providers run out of session time. However, the lack of national standards and oversight makes it difficult or impossible to assess how well advocacy providers are operating overall. The current Advocacy Quality Performance Mark (QPM), developed by the National Development Team for Inclusion, is an effective

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means of ensuring consistency across the service, but is currently voluntary. The fourth edition of the QPM was formally launched in May 2018, and is available to statutory and non-statutory independent advocacy in England/Wales/Northern Ireland. Whilst generally acknowledged as robust, and a helpful mechanism to raise the general quality of advocacy provision, criticism of the existing framework includes the upfront cost necessary to undertake the QPM assessment – thereby acting to exclude smaller providers, often themselves able to provide more tailored services eg culturally-sensitive. Any potential rollout would thus need to mitigate against the risk of dis-incentivising smaller providers, traditionally able to provide a more flexible and responsive services, possibly through alliances of providers or similar.

Fundamentally, the lever for change in terms of advocacy quality is through the commissioning/contracting process. A requirement for commissioners to start awarding contracts based on adherence to the QPM (or similar framework) by providers, which includes an expectation for an appropriately trained and skilled workforce, would result in improvements across the board.

In addition, there may also be a role for a national oversight body to establish the required standards (whether the QPM or otherwise) and monitor quality, including setting the required curriculum for the training of IMHAs and other advocates. Initial conversations with Health Education England have raised the possibility for this body to be housed within the Health and Care Professions Council; exploration of the remit of such a body, including potential oversight of other forms of statutory advocacy as well as IMHAs, needs further consideration. Regardless, the improvements to the feedback loop between existing actors, as well as clearer escalation procedures, would in and of themselves have the potential for great benefit.

Evidence and analysis

Responses from professional bodies to the Review's call for evidence focussed on the need for appropriate training of IMHAs to respond to the needs of protected groups, with specialist knowledge of legislation to advocate appropriately for them.

Further, in relation to the quality of services and oversight of advocacy providers, patient advocacy organisations raised that the Scotland 2003 Act requires local authorities, Health Boards, and the State Hospitals Board for Scotland to provide information to the Mental Welfare Commission (the Commission) about how they are meeting their duties under the 2003 Act to provide independent advocacy services, at least every two years or when asked to do so by the Commission. The model adopted in Scotland corresponds with the potential need for an oversight body in England/Wales, which requires further consideration.

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Finally, an NHS trust noted problems with access to IMHA services given the organisation personally has no responsibility or authority in the commissioning or monitoring of the services provided. This endorses the need for greater collaboration between commissioners, advocacy organisations and trusts in delivering the service.

Implementation considerations

Revisions to the current training package for IMHAs will require consultation with current training provider (City and Guilds) to tailor the course content and structure appropriately. This would also helpfully involve consultation with providers and commissioners on the current training package.

Changes to monitoring of quality by commissioners would involve consultative work with LAs to determine the current process of contractual feedback, as well as the potential opportunities/models whereby input from a wider number of parties (beyond the provider) could be incorporated. This is likely to mean a significant ramping up of responsibility on the commissioner to regulate the service eg by convening appropriate panels of external individuals to provide independent feedback etc.

Mandating the principles of the current QPM will require a detailed piece of work, in consultation with the National Development Team for Inclusion (NDTi), to develop a robust framework against which providers could be assessed and contracts awarded by commissioners accordingly. Central to this would be the need to prevent undue barring of access to providers (particularly smaller organisations providing bespoke services).

Further conversations with Health Education England are also outstanding regarding the potential options for a statutory body to provide oversight.

5. Improving service quality

Issue

Quality of service provision is difficult to ascertain from an external perspective, and often varies between individuals and wards within single trusts. Inspections, such as those undertaken by the CQC, provide a valuable insight into overall service provision, but are often limited in terms of generalisability due to the short-term nature of an interview/inspection-based approach – as well as the inability to respond to individual concerns.

Advocates and advocacy organisations have a unique perspective on the quality of services provided to the individuals, due to their extended presence on wards and direct involvement helping individuals to understand and exercise their rights in that context. Currently, this valuable potential feedback is too often overlooked.

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Recommendations

Recommendation 5a: Advocacy providers should be required to provide quarterly reports about issues and trends, without compromising their primary duty to individual clients.

- This could potentially link in with the revised role of hospital managers as “quality tsars” proposed by other areas of the review.

Rationale

IMHAs are well placed to provide feedback on quality of service provision, regularly interacting with staff involved in a person’s care and spending extended periods of time in the ward environment. However, there is currently no formal external mechanism available to an advocate to raise any concerns – beyond anything which constitutes an emergency situation (eg patient safety).

As such, if CQC are visiting, inspectors should always speak to advocates about service quality. Further, if the recommendation is made for hospital managers to become roaming quality inspectors, then advocates could play a helpful role in feeding into this process. Key to both scenarios, however, is the need for an external outlet beyond direct conversation/conflict with staff within the hospital setting. This is both in recognition of existing power imbalances between advocates and clinicians, as well as the need for greater consistency and accountability when assessing the quality of service provision.

Although an appreciation of the competing calls on IMHAs’ time will need to be factored into any potential interviews, as well as adequate assurances to allow for honest feedback without the risk of future ramifications, the responsibility itself should have minimal impact upon existing duties.

A linked point concerns the Use of Force Bill (Seni’s Law). An early draft of the Bill contained provisions about advocacy, which were removed in part because the topic is being examined by the review. The role of an IMHA to address possible power imbalances between patients and clinicians in situations where force and coercion are used is paramount – and is therefore a central part of the training revisions suggested at 4a. Further, beyond the point of immediate de-escalation, the ability for the advocate to report/escalate instances in which force has been used inappropriately to an external body is equally necessary to improve clinical practices and ensure patient safety.

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Evidence and analysis

Anecdotal evidence from advocacy providers emphasises the value of advocates' knowledge in relation to hospital practices and procedures. Further engagement would be necessary to determine the extent to which this could be utilised.

Implementation considerations

Any additional duty on advocates to act in a quality improvement capacity (in reflection of service provision) may require legislative change. Regardless, contractual negotiations between commissioners and advocacy providers will need to ensure sufficient flexibility (and resource) to cover any such limited additional calls on IMHAs' time – and therefore further guidance may be necessary.

This is also reliant on appropriate wider mechanisms of feedback and escalation – potentially aligning with the revised role of hospital managers (with thinking being taken forward across the wider Review). The suggestion for CQC to interview advocates as part of trust inspections would require further conversation, and any potential conflict of interest between IMHAs commissioned role (by LAs) and subsequent expectations (by health bodies) would need to be considered.

There should be minimal additional cost implications beyond those associated with improved access and wider changes to the role of IMHAs suggested above.

6. Culturally-appropriate IMHA services

Issue

General advocacy services are often unable to respond effectively to the needs of certain minority ethnicities, resulting in either a total lack of support or else an inability to deliver effective advocacy provision. Inadequate advocacy results in even greater disparities in experience and outcomes for certain minority ethnicities.

Recommendations

In line with the recommendations of the African and Caribbean (MHARAC) and Asian and Minority Ethnicities topic groups, and in addition to other recommendations above:

Recommendation 6a: Supporting the development of greater cultural competence across a discrete cohort of the existing (and future) IMHA workforce, with the potential for specific race equality advocates where appropriate.

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Rationale

The current Code of Practice states that local authorities should ensure that IMHAs understand equality issues and that there are enough IMHAs with specialised understanding of, and ability to communicate with groups including:

- patients from minority cultural or ethnic backgrounds;
- patients with physical impairments and/or sensory impairments; and
- patients with learning disabilities and/or autistic spectrum disorders.

Current IMHA provision is often unable to fulfil the diverse needs of individuals of Black, Asian and Minority Ethnic groups. Whilst enhanced training in relation to cultural competence will help in terms of greater understanding across the current IMHA workforce, evidence is growing in support of specific (and additional) race equality advocates in seeking to address multiple disadvantages.

An NHS England pilot is currently underway across forensic services in Birmingham which incorporates a 10-day training programme for race equality advocates, co-produced with experts by experience. The outputs from this pilot will be helpful in determining critical elements (and delivery) of a future cultural competence training package for IMHAs.

Advocacy is a vital tool to create links with communities that are otherwise excluded. To support this we are calling for a greater focus within advocacy training on working with diversity (including placements), more community advocacy and peer support work and career pathways from peer support / community advocacy into IMHA advocacy

Evidence and analysis

The evidence base in support of specific provision of race equality advocates includes existing academic reports which encourage commissioners to recognise the distinct experiences of African and Caribbean men and to develop capacity in the range of organisations to ensure equitable access (Newbigging, McKeown & French, 2011).

Further, the scope for patient choice of advocate was a theme raised by patients and carers in response to the review's survey:

"...The patient should have the right to ask to see anyone they like, nominate anyone as a advocate..." (LEX 60)

Implementation considerations

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Existing guidance in the Code of Practice fails to support a tailored response to the population needs of a certain geographical area, including but not limited to different ethnic communities. This will need to be addressed to ensure a robust service response.

The commissioning of specific advocates to cater for the needs of particular individuals, over and above current IMHA provision, is likely to have significant additional resourcing and financial implications. However, the potential for reduced length of stay could outweigh any upfront development.

Additional areas for further consideration

A number of issues were raised within the group, and by others, which were unable to be considered in detail due to time constraints. These include, but are not limited to:

- Specific, dedicated advocacy provision to cater for the specific needs of 1) children and young people and 2) individuals with a learning disability or autism
 - Issues have concerned the inappropriate skill set of current IMHAs to deal with the needs of these groups effectively, as well as conflict between different forms of statutory advocacy. For example, a child with a learning disability could be entitled to three or four different forms of (statutory) advocacy.
- Private providers commissioning advocacy services directly
 - A common breach of 'independent' advocacy services is found within certain private providers, who commission the service directly. This is a conflict in responsibility for the advocate who, as a part of his/her role, should feel empowered to make objective judgements in relation the practices and processes concerning the patient without risk of negative ramifications.
 - Limited consultation on this point reveals some challenge from stakeholders given the practical need for certain private hospitals to commission advocacy provision directly due to limited IMHA provision in certain geographical areas. In doing so, more patients have access to independent support and their rights protected. Clearly, therefore, this point needs further exploration and the merits of each argument should be evaluated more formally.

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- The right to an advocate at the point of making an advance decision-making document or nominated person nomination
 - The argument for IMHAs to play a more active role in care planning may appropriately extend to the point at which a patient is making an advance decision-making document. This process could benefit from the involvement of an advocate, particularly if making potentially binding decisions regarding future nominated person (as per the family and carer involvement group's emerging recommendations). Both processes require an understanding of the MHA and how to exercise rights under it, which an advocate is well placed to provide.
 - However, the practicalities of advocacy involvement at this stage will need further consideration. For example, whilst the skill set of an IMHA may be appropriate in certain circumstances, the broader perspective of non-statutory provision may be preferable in others. Furthermore, the logistics of involvement (including funding, setting and responsiveness) will need to be balanced with the potential benefits of such a presence.

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Annex 1: Implementing opt out for independent mental health advocacy: questionnaire for advocacy providers

	seAp Plymouth	Advocacy Focus	seAp Cornwall
When was this introduced for your service?	It was introduced 3 years ago (2015) in the Plymouth service and all seAp IMHA services operate this model.	This was introduced to Advocacy Focus in 2014.	This was agreed with the Cornwall Foundation Trust senior management in October 2016 following the 2015 guidance produced by the Social Care Institute for Excellence (SCIE) recommending that IMHA services should be opt in.
How does it work?	<p>seAp follows the Mental Health Act 1983: Code of Practice. Although this is not a full opt out service, seAp is able to get a very high rate of referrals for IMHA. This is because we have been able to build up close working relationships with MHA Administrators and ward managers. We have also provided training to ward staff by being involved in the MHA training delivered by the hospital and on separate ward training sessions.</p> <p>All patients who do not have capacity to request or decline an IMHA are referred to the service by ward managers and seAp has arranged with MHA</p>	The Protocol works as a guidance for all the professionals involved with service users once they are admitted into hospital. Once admitted on a ward it's the nursing staff's responsibility to inform service users of their s.132 rights. The nursing team inform service users that they are entitled to an Independent Mental Health Advocate and unless they opt out a referral for an advocate will be made. If service users agree their details are then passed onto the hospital Mental Health Act Admin. Mental Health	The Mental Health Act Office has updated the trusts s.132 Checklist. This is the checklist used by the hospital to inform patients of their statutory rights. This was updated to say that patients should be asked if they object to being referred to the IMHA service and should be referred accordingly, providing they do not voice an objection. It was also updated to say that people who lack the capacity to understand their rights should be automatically referred. This is in

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	<p>Administrators to have this indicated on the s.132 forms. Any failure to refer such patients is picked up by the MHA Administrator and referred to us. IMHAs receive referrals directly from hospital staff via email or telephone or, indirectly, through our Contact Centre.</p> <p>seAp runs regular weekly outreach services to the wards and are present frequently on the wards at other times. The strong presence of advocacy on the wards means that patients can approach IMHAs and self-refer. It also means that patients can get a referral to an IMHA easily at any time during their detention. The outreaches are often set near ward round times, so that patients can get access to an IMHA to support them in meetings.</p> <p>Under the current law, AMHPs and responsible clinicians should consider requesting an IMHA to visit a qualifying patient if they think that the patient might benefit from an IMHA's visit but is unable, or unlikely, for whatever reason to request an IMHA's help themselves. This is often delegated to ward staff. When IMHAs visit the wards, on their outreaches, they ask hospital staff whether there are any patients whom they think may benefit from an IMHA but are unable or unlikely, for whatever reason, to request one. seAp receives a lot of referrals this way. It is not</p>	<p>Act Admin then collate a list of all the service users who require an advocate and email AF (via secure email) once per week.</p> <p>If service users are lacking capacity then their details are passed onto advocacy in their best interest.</p> <p>Once AF receive the referral for an Independent Mental Health Advocate. Advocates are allocated and make first contact with the service user within 48 hours and arrange to meet their service users on the ward they are on.</p> <p>Service users can decline the IMHA service once an advocate does visit them on the wards. Service users who initially declined the IMHA service can also speak to advocates and volunteers to self-refer.</p> <p>Service users who are subject to the Mental Health Act in the community are also entitled to an advocate. Care co-ordinator will go through the s.132 rights with the service users and again pass on their details to the Mental</p>	<p>line with the MHA revision in 2015.</p>
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	<p>uncommon for a patient not to request the service or even decline it, when offered by staff, only to agree to it once an IMHA visits and interviews them. The only patients who would not be referred to our service are patients with capacity, whom hospital staff do not believe would benefit from the service and where they know, or strongly suspect, that the patient does not want an IMHA. This is the only real difference between seAp's protocol and a full opt out system. SeAp has produced a Hospital Staff leaflet which explains the referral protocol.</p> <p>seAp has IMHA Patient Information leaflets on all wards and we have arrangements with MHA Administrators that they send out details about our IMHA service to all patients who are subject to CTOs and Guardianship, enclosing our IMHA patient leaflet, each time they send them correspondence. We are also included in the Hospitals' 'Welcome to the Ward' booklets for patients.</p>	<p>Health Act admin who will email AF.</p>	
<p>What has been the impact on referrals of introducing opt out for IMHA</p>	<p>Referrals have increased, since we introduced the outreaches and the training for hospital staff.</p>	<p>AF has increased the number of referrals since the opt out policy has been in place.</p>	<p>We've seen an increase in referrals but not to the extent we might have expected. I think there is more work to do in promoting this way of working. We will look to do this when we have adequate staffing numbers to meet an increased demand on the service. This will hopefully be</p>

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			possible soon with the recent appointment of a new IMHA.
Have there been particular groups of people that have benefitted from an opt out approach?	<p>People who lack capacity. Also, it is not uncommon for a patient with capacity to decline the service, when offered by staff, only to agree to it once an IMHA visits and interviews them. We have often been able to see these patients under the criteria that they might benefit from the service and that staff believe that they would want an IMHA once introduced to one.</p>	<p>Having a protocol in place has enabled staff to automatically refer patients who lack capacity in relation to their detention, care and treatment. It has generally increased referrals as staff are prompted to ask the question and more people are told about their rights under the MHA including the right to advocacy. It is at the forefront of professional's minds when people enter hospital meaning people have access to advocacy support quicker and at the start of their detention.</p>	<p>I feel this way of working is crucial in engaging the less vocal people who are less proactive in seeking support. These are often the people who would benefit the most from advocacy involvement as they are less able to actively assert their needs, wishes and preferences to professionals.</p>
What do think the strengths of an opt-out approach are?	<p>A full opt-out service would improve referrals to IMHA services who do not have comprehensive outreach and close partnerships with service providers.</p> <p>The strengths of our outreach services</p> <ul style="list-style-type: none"> - Patients and staff are reminded of the advocacy service at least on a weekly basis - Patients can change their mind easily if they want to see an advocate 	<p>The opt out policy has set clear guidance on when service users should be informed of advocacy. This has then set clear guidance on how professionals take the details of service users and share them with AF. The opt out policy has helped expand the reach of advocacy support, ensuring everyone is made aware, and early referral takes place.</p>	-

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	- The advocate is known and trusted on the ward.		
What are the difficulties with an opt out approach?	<p>Although this has been recommended by the CQC and the Health Committee of the House of Commons, a full opt out approach may be unlawful and a breach of confidentiality on the part of the hospital.</p> <p>Even if the law was changed, in terms of opting out, IMHA providers must ensure that they select the correct lawful basis for processing under GDPR ie Legal Obligation.</p>	One of the main difficulties initially faced was nursing staff not going through the s.132 rights with service users at the earliest opportunity. Also, service users can change their mind after having initially declined the IMHA service, it will need some dedication from your team to get professionals on board and discussing advocacy with the detained individual to ensure they can have a referral if they change their mind.	The difficulties are in making sure this model is properly being implemented by professionals. I think the people who would object to being referred to advocacy are in the minority, especially if the potential benefits of IMHA involvement are adequately explained to them. I anticipate the increase in referrals to be huge if this system is being followed in every instance. I'm however concerned that in practice the time constraints on ward staff are discouraging them from taking the time to refer.
Are there any potential unintended consequences of an opt out approach for IMHA?	There is the possibility that, although there may well be an increase in referrals, these are likely to be for patients whom hospital staff strongly suspect do not want the service. It is important to maintain the 'patient may benefit' referral, so that patients who decline the service due to eg mistrust of the hospital, the independence of the IMHA service or as a direct result of symptoms of their mental disorder, are not immediately treated as 'opted out.'	<p>None noted other than benefits to the person.</p> <p>You must ensure all referrals are sent securely in line with GDPR</p>	The patient should be given a clear opportunity to object to our involvement. Without this Advocacy risks being another unwanted imposition on the person's autonomy and right to confidentiality.
What are your recommendations to	- Work with the Mental Health Act Administrator to set up and deliver IMHA training sessions to educate Ward	- Implement opt out protocols across your hospitals	Updating the s.132 documentation is key. We are also looking to request a change

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<p>improve access to IMHA services?</p>	<p>Managers and staff about their responsibilities to inform and refer</p> <ul style="list-style-type: none"> - Have an IMHA slot in their regular MHA training. - Add information about the IMHA service to s.132 rights form and a statement that all patients who lack capacity must have a referral to an IMHA - Produce and distribute an IMHA staff information leaflet in addition to advocacy patient information leaflet. - Be proactive and conduct regular weekly outreaches to all the units, so that there is always a physical advocacy presence on the wards. - Maintain close working relationships with ward staff. 	<ul style="list-style-type: none"> - Run regular drop ins on the wards - Improve access to information packs for detained patients, service leaflets and more. - Maintain relationships with key professionals to increase referral rates and have a presence on the wards. 	<p>to Cornwall trusts database so that the member of staff informing the patient of their s.132 rights must document and date a patient's objection to being referred. This will hopefully reinforce their duty to refer where an objection has not been expressed. I feel that improving ward staff's training and understanding of their responsibilities/legal duties under the Act are also vital in supporting patients access IMHA support.</p>
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Annex 2: Different types of advocacy

Service	Eligibility	Role of Advocate	Qualifications/Training	Interrelationship
IMCA	<p>The person is aged 16 or over</p> <p>A decision needs to be made about either a long-term change in accommodation or serious medical treatment</p> <p>The person lacks capacity to make that decision, and</p> <p>There is no one independent of services, such as a family member or friend, who is "appropriate to consult"</p> <p>An IMCA may also be provided to people for other decisions concerning</p> <p>Care Reviews, or</p>	<p>Advocates will work with the person lacking capacity, to try and establish their views and to involve them in the decision-making process as much as possible. They will also speak with people who may have information about the person's views, beliefs, and preferences, and will consult any written information such as case-notes and reports, or directions which the person may have given before they lacked capacity.</p> <p>They will write a report which outlines their findings on the likely views of the person, detailing how they arrived at their recommendations. Decision-makers have a responsibility to give full consideration to the contents of the report.</p> <p>If agreement cannot be reached, IMCA staff can challenge the decision-making process by using the local complaints procedure or referring it to the court of protection.</p>	<p>The MCA specifies that LA's should satisfy themselves that IMCA's have appropriate training and/or experience.</p> <p>DHSC recommend that Commissioners of IMCA services include criteria in the service providers contract requesting practising advocates complete and gain the City and Guilds IMCA Unit 305 accreditation.</p> <p>IMCA accreditation is competency based so learners need to be practising IMCAs.</p>	<p>IMCAs can support someone during adult protection procedures.</p> <p>IMCAs can support someone whose care plan is being reviewed.</p> <p>IMCAs work with a person once they have been assessed as requiring a long-term change in accommodation, whereas a Care Act Advocate will be involved much earlier, from the assessment stage.</p> <p>IMCAs will provide support where a person lacks capacity, so a capacity assessment must be completed. Eligibility for Care Act Advocacy is determined by a person's significant difficulty in</p>

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	<p>Adult Protection</p> <p>In adult protection cases an IMCA may be instructed even where family members or others are available to be consulted.</p>			<p>participating in the decision-making process.</p>
<p>IMCA (DoLS)</p>	<p>IMCAs must be instructed for people who are being assessed as to whether they are currently being, or should be deprived of their liberty, where there is no-one “appropriate to consult”</p>	<p>S.39A IMCAs are instructed when there is an assessment in response to a request for a standard authorisation, or a concern about a potentially unauthorised deprivation of liberty.</p> <p>S. 39C IMCAs cover the role of the relevant person’s representative when there is a gap between appointments.</p> <p>S.39D IMCAs support the person, or the relevant person’s representative, when a standard authorisation is in place.</p>	<p>Law states appropriate training and experience. DHSC guidance suggests that practising IMCA DoLS should complete and obtain IMCA unit 305 and DoLS unit 310 accreditation.</p>	

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<p>IMHA</p>	<p>People who are detained under the MHA or subject to CTOs within the funding local authority area. Also, any person who is received into guardianship by the local authority. These are known as Qualifying patients</p>	<p>The help IMHAs give to qualifying patients must include, as a minimum:</p> <ul style="list-style-type: none"> - their legal rights under the MHA - the legal rights which other people (eg nearest relative) have in relation to them - the particular parts of the MHA which apply to them - any conditions or restrictions to which they are subject - any medical treatment that they are receiving or might be given, and the reasons for that treatment - the legal authority for providing that treatment - the safeguards and other requirements of the Act which would apply to that treatment. <p>IMHAs help patients to exercise their rights, which can include representing them and speaking on their behalf, eg by accompanying them to review meetings or hospital managers' hearings. IMHAs support patients in a range of other ways to ensure they can participate in the decisions that are made about their care and treatment, including by helping them to make applications to the Tribunal.</p>	<p>The Regulations state that people can only act as IMHAs if they have satisfied certain requirements as to experience, training, good character and independence. Guidance on what constitutes appropriate experience and training</p> <p>for this purpose has been published by the Secretary of State for Health.</p> <p>The guidance includes an expectation that IMHAs will normally have completed the IMHA 306 Unit of the independent advocacy qualification by the end of their first year of practice;</p> <p>IMHA services are specialised and require a high degree of knowledge and expertise to work within the framework of the MHA which is complex and demanding.</p>	<p>MHA usually trumps the MCA. An IMCA does not need to be instructed for an accommodation decision if the person is being required to stay in the accommodation under the MHA eg guardianship and an IMHA would also be the advocate involved if treatment is being given under the MHA. The only time that there might be two advocates involved is where a MHA qualifying patient lacks capacity and is being discharged to new accommodation not under the MHA, if the patient is being considered for serious medical treatment not under the MHA or in some safeguarding situations.</p> <p>The Care and Support statutory guidance (which applies to the Care Act) makes clear that an IMHA can assist MHA qualifying patients in their Care Act Assessments, as an appropriate person to represent and support the individual for the purpose of facilitating the individual's involvement. There is no need, therefore for a separate Care Act Advocate.</p>
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<p>Care Act</p>	<p>Adults and Carers who have substantial difficulties in participating in care planning and reviews and who have no appropriate person to help them.</p> <p>Young people and young carers in transition from children to adult services</p> <p>Young Carers</p> <p>People who are subject to safeguarding enquiry and review</p> <p>Even if a person has an appropriate individual to facilitate involvement in the process, they are still</p>	<p>Advocates primary focus must be the wellbeing of the person.</p> <p>They help a person to:</p> <ul style="list-style-type: none"> • Understand and engage in the process • Communicate their wishes, views and feelings • Make decisions and challenge those made by the local authority • Understand their rights • If appropriate, look at relevant health and social care records • Talk to those who can help • Consult the family and others if the person does not have capacity • Support and represent them in the safeguarding process 	<p>The Care Act states that once appointed, all independent advocates should be expected to work towards the National Qualification in Independent Advocacy (level 3) within a year of being appointed, and to achieve it in a reasonable amount of time. Since the Act was published, the DHSC has also recommend that Care Act Advocates obtain Care Act unit 313</p>	<p>Both the Care Act and MCA recognise the same areas of difficulty, but the test with the MCA is whether the person 'lacks capacity' in relation to a specific decision whereas with the Care Act it is having 'substantial difficulty' in being involved in key local authority processes.</p> <p>The role of an 'appropriate individual' under the Care Act is fuller and more demanding than that of an individual with whom it is 'appropriate to consult' under the Mental Capacity Act (MCA). Under the Care Act the appropriate individual's role is to facilitate the person's involvement (in much the same way as an advocate would eg using principles of being person centred, empowering and helping the person participate in the decision-making process), not merely to consult them and not to make decisions on their behalf.</p>
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	<p>eligible for Care Act Advocacy if:</p> <p>A placement is being considered for an NHS funded stay in hospital (for a period exceeding 4 weeks) or a care home (for a period exceeding 8 weeks)</p> <p>There is a disagreement between the local authority and the appropriate person, and it is agreed that the person would benefit from having an advocate</p>			
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Annex 3: Indicative wording for the amendment

Add to s.130B of Mental Health Act 1983 a new duty that the help that IMHAs provide must include help obtaining information about and understanding [new subsections]:

- '(g) any statutory care plan that is proposed, agreed or discussed in his case
- (h) the reasons for any proposed course of action set out in any statutory care plan
- (i) rights relating to the use of advance decision-making documents'

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Tribunals, hospital managers, renewals

Chair: District Judge Professor Anselm Eldergill - Court of Protection Judge

Working group lead: Alex Ruck Keene (barrister)

Secretariat: Sarah Palmer

Membership

- Ian Callaghan (Rethink)
- Joanna Dean (Mind)
- Sophy Miles (barrister)
- Joan Rutherford (Chief Medical Member, Mental Health Tribunal)
- Dr Ben Spencer (Consultant Psychiatrist)
- Dr Anna Thomas (Medical Deputy President, mental health review tribunal for Wales)

In addition to the core membership, the topic group may bring in expert contributors for specific issues within the topic, or to test emerging findings:

- Statutory justice bodies to join for appropriate meetings in an observer role (England and Wales as appropriate).
- Hospital manager to join for relevant discussions.
- Additional experts and practitioners who will be invited to feed directly into the topic group's work and/or join to provide evidence and ideas in relevant meetings.

Terms of reference

Remit

The interim report said the review 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

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- 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

This group will also look jointly with the Criminal Justice System group at tribunal issues relating to restricted patients. The Criminal Justice System group will formally own tribunal issues for restricted patients in terms of reporting.

This group will also consider whether there is the right scrutiny each time the 6/12 month renewal point is reached, including whether AMHPs should have a role here.

The topic group will consider how current inequalities can be addressed in relation to the Mental Health Act, and any recommendations will consider the potential impact upon individuals identifying with protected characteristics under the Equality Act 2010. In particular, the review is seeking to address racial disparities, with a specific emphasis on people of African and Caribbean descent or heritage.

The purpose of this group is to identify potential recommendations the review could make in relation to the above, and to support the review's overarching goals (see below).

Timing and outputs

i. Review point:

Gap analysis and any additional research requirements by 31st May.

Progress update to the review by 20th July 2018.

ii. Final report

The group will to produce a short report to the review leadership by [21st] September 2018, using the agreed format, setting out key findings for consideration by the Review as they prepare their final report and recommendations to government.

The topic group's work will be supplemented by additional engagement activity. Strong engagement with Welsh Government and the Welsh Tribunal will be important since justice (including both substantive powers and procedural rules for MH Tribunals) is not devolved, but funding responsibilities lie with HMCTS for the FTT (MH) in England, and Welsh Government for the MHRT.

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Interdependencies

This topic group will need to connect and share information as appropriate to the following other topic groups:

- Patient autonomy – in relation to treatment safeguards
- Family/carer involvement – where should issues relating to nominated persons be resolved
- Discharge and aftercare – for any consideration of Tribunals powers to direct service provision in relation to aftercare
- Mental Capacity Act interface – to ensure coordination as regards potential appeals from LPS authorisations and MHA detentions, as well as 'dual-ticketing' where both LPS and MHA if those still occur
- Detention criteria – important as are also in effect discharge criteria, and relevance in connection to renewals, any interaction with ideas to combine or reconfigure sections 2 and 3 of the MHA
- Criminal Justice System – to ensure coordination about restricted patients
- Understanding why rates of detention under the MHA have increased – insights will inform this group and we may identify relevant sources for this work

Goals set out in the review's interim report

- 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

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- Reduced harm and improved safety for all
- Professionals better able to deliver their expertise

Report

1. Issue

This group has been concerned with the provision of safeguards – checks and balances – against the decisions to detain a patient and treat them against their will. The current set of safeguards have been in place for some time, and are out of step with a modern mental health system. They do not necessarily provide the most effective means of ensuring that both detention, and the treatment administered whilst detained, are absolutely necessary, when balanced against the rights of the individual. In particular there is a need to improve our compatibility with the European Convention on Human Rights regarding challenges to compulsory treatment.

We have considered:

- The powers and procedures of the First Tier Tribunal/Mental Health Review Tribunal for Wales (together called in this paper 'the Tribunal');
- The ability of a patient to challenge the treatment they receive;
- The process for renewals of detention;
- The role of Associate Hospital Managers;
- Transparency of the Tribunal; and
- Victim Personal Statements

The topic group also considered what revisions are necessary to Part V of the 1983 Act, in the light of experience of those provisions over 35 years, and propose the amendments set out in Annex 1 to this report.

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2. Findings

Note: the support of the medical and Tribunal members of the topic group for the recommendations made was contingent upon adequate resourcing being available.

Tribunal Powers

Recommendation 1 – the powers of the Tribunal should be expanded to enable it to consider whether patients are receiving appropriate care and treatment, and that any conditions imposed are justified. This includes:

- reviewing the appropriateness, and delivery, of new statutory care and treatment plans for detained patients.⁴²
- reviewing and making changes to conditions of both detention and treatment in the community, including leave, transfer, community treatment orders and conditional discharge;
- a limited power to direct services in the community to support discharge decisions; and
- (subject to procedural safeguards) a power to make findings in relation to breaches of the Human Rights Act 1998.

Tribunal Procedures

Recommendation 2 – that there is sufficient access to the Tribunal for patients and their representatives to appeal against their detention/otherwise being subject to the MHA. This includes:

- a power for hospital managers, the SOAD and the CQC to refer patients to a Tribunal, extended to Independent Mental Health Advocates (IMHAs) and nominated persons for patients who lack capacity;
- automatic references at 4 months (from the point of detention), if this can be resourced, otherwise 7 months, and then at a yearly basis, such automatic references also to be extended to community provisions; and

⁴² The topic group identified that more work will be required to 'mesh' this recommendation with the mirror recommendation of the detention criteria group, and to identify the Tribunal's precise powers upon review, and that this is a matter likely to require consultation by government in due course.

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- in relation to detention under s.3, requiring the RC to certify a specific number of days in advance of a Tribunal that the patient continues to meet the criteria for detention.

Recommendation 3 – that the Tribunal procedures be amended to enable applications to be determined in a timely, proportionate and effective fashion, taking into account the interests of both patients and the public, through:

- enabling case management decisions to be taken by a single judge where appropriate, although requiring all substantive decisions to be taken by a panel of three at a hearing except where the patient requests otherwise;
- giving the Tribunal powers to make costs orders in appropriate cases to reflect conduct;
- development of a system of accredited training for panel members in specialisms including children and young people, forensic, learning disability / autism, and older people; and
- collection of statistics on the protected characteristics of those applying for a Tribunal hearing, and their discharge rates.

Treatment Challenges

Recommendation 4 – that there be an effective route of judicial challenge to specific individual treatment decisions made by the patient's Responsible Clinician (RC), the precise route requiring further investigation and consideration.

Hospital Managers

Recommendation 5 – that Associate Hospital Managers no longer have the power of discharge, and they are reconstituted as new independent bodies called 'Hospital Visitors' with two functions: (1) to monitor day-to-day life in the hospital, reporting to the hospital governors (or equivalents); and (2) to exercise powers in relation to specific patients, including:

- requiring an RC to explain care and treatment decisions being taken in relation to the patient (eg use of seclusion/restraint);
- requiring the RC to make a referral to a SOAD; and
- referring a patient's case to the Tribunal in specified circumstances.

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Renewals

Recommendation 6 – that periods of detention under s.3 should run for 3 months, 3 months, 6 months and then 1 year thereafter, renewable by the patient's RC (the group being told that AMHP involvement, whilst desirable would be unlikely to be achievable in practice).

3. Rationale

Tribunal powers

The overriding rationale for expanding the powers of Tribunals is that their current role, which is limited to considering whether or not the patient meets the statutory criteria for detention under the MHA, does not provide an adequate safeguard against wider infringements of a patient's rights.

We heard that when considering whether or not someone needs to be detained in hospital, the detention should be thought of as integral to the overall treatment 'package' - the need to admit someone is inextricably linked to the need to administer treatment to them. The Tribunal should therefore be able to consider what treatment is being delivered, and what is planned, in order for them to properly consider whether the person's detention is justified. This will ensure that, at the point of an application for discharge, patients are only detained in hospital where (a) there is a clear plan for their care and treatment; (b) that care and treatment is in fact being delivered; and (c) it is strictly necessary for the care and treatment to be delivered in hospital. The topic group considered but ruled out the ability of the Tribunal to direct that specific care and treatment be provided, a key reason for ruling this out is that this would be to blur the lines between a judicial and an authorising body, which the topic group considered should be maintained. However, a Tribunal should be able to exercise case management powers to adjourn cases and indicate to the service providers that they will discharge the patient if the care specified is not subsequently delivered. This will give teeth to its review functions. The group considered, but ultimately did not propose, that the Tribunal be given the power to consider care and treatment plans separately to consideration at the point of an application for discharge. The topic group identified that more work would be required – in conjunction with those responsible for the 'mirror' recommendation from the detention criteria topic group – to identify the precise powers of the Tribunal upon review. Given the implications, this is a matter likely to require consultation by government in due course.

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The review heard from many sources that discharge is often delayed because of a lack of service provision in the community, including accommodation, health and social care. The rationale for the Tribunal to have a limited power to direct service provision outside hospital is that this will facilitate discharge of patients who are detained in hospital solely because a service identified as necessary by their treating team is not being provided, thereby avoiding arbitrary interferences with patients' rights under both Articles 5 and 8 ECHR.

We heard from members of the judiciary, from lawyers and from service users that they would like the Tribunal to be able to direct transfer and leave of absence. In this way, if they do not feel a discharge is warranted, they may be able to help a patient to move towards discharge by, for example, directing that a patient is tried out on leave before their next application. We also heard that stakeholders want the Tribunal to be able to vary the conditions of CTOs and conditional discharge for the same reasons. We also understand that the CTO and Criminal Justice System topic groups will be recommending a statutory review of CTO and conditional discharge decisions to prevent people remaining under their conditions for unnecessarily long periods of time. In similar vein, the Tribunal should be able to have the power – where the provision is available – to direct that a patient be moved to a lower security hospital. Taken together, this will mean that the Tribunal has the necessary powers to consider matters consequential upon the patient being subject to the MHA 1983 that directly impact upon their rights under Article 8 ECHR.

The topic group considered that there was considerable force in the observations of Charles J in *PJ v A Local Health Board and Others* [2015] UKUT 480 (AAC) about the anomalous absence of powers for the Tribunal to consider matters arising under the Human Rights Act 1998. The group recognised that there was a balance to be struck between (1) enabling the Tribunal to respond to an obvious and stark breach of an individual patient's human rights (where that breach did not, itself, mean that the criteria for detention were no longer met); and (2) burdening the Tribunal with a satellite jurisdiction to consider these claims. The group considered it would be possible for that balance to be struck by giving the Tribunal the power to record findings in relation to breaches of the HRA, subject to appropriate case management (including, in particular, a requirement that any such claimed breach is identified in advance by the patient's representatives).

Procedures

Frequency of access to the Tribunal: The topic group considered that there needed to be a balance struck between, on the one hand, securing the right to challenge detention before a tribunal under Article 5(4) ECHR (which is not contingent upon success); and on the other devoting such resources to securing frequent access to the tribunal that they are not available to be spent elsewhere. The topic group considered but ultimately rejected the approach of being able to make an unlimited number of applications to the Tribunal (with a permission filter exercised by the single judge, on the basis of a change of circumstances) in favour of maintaining, in general, the current approach of enabling one right of challenge per detention period, combined with granting a power to relevant individuals/bodies (hospital visitors, the SOAD, the CQC) to refer a case to a Tribunal. The topic group recognised that this would require modification if the review were to recommend that s.2 be broken down into an initial 14 day period, renewable once; it would be very unlikely that a workable process could be derived to ensure that hearings could always be listed within that initial period.

The topic group recognise that condensing the initial periods of detention under s.3 would be likely to lead to an increase in applications to the Tribunal. However, the level of increase may be limited by other measures (including eg requiring greater focus on the care and treatment plan, greater weight to be placed upon the person's wishes in the context of care and treatment, and the new role for associate hospital managers) which are likely to lead to greater focus by the RC, at an earlier stage, of the necessity of the patient remaining in hospital. In the context of detention under s.3 MHA 1983, we also think that requiring the RC to certify a specific number of days (the group suggest this might be 10 working days) in advance of a Tribunal hearing that the patient continues to meet the criteria for detention, will focus minds on suitability for discharge at the earliest opportunity rather than when a Tribunal is about to sit. These additional safeguards may limit either the number or impact of increased applications.

Securing access to the Tribunal: The topic group was clear that there needed to be provision for automatic references to a Tribunal to secure an effective right of challenge to those patients who either through lack of mental capacity or timidity, fear or passivity do not take steps to challenge the fact that they are subjected to the MHA 1983. The group considered that this should be:

- at four months from the date of initial detention (if this can be resourced), otherwise 7 months;
- yearly thereafter in all cases (including guardianship, CTO and conditional discharge)

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The topic group was clear that, insofar as possible, mental capacity should not be operated as a bar to bringing proceedings before the tribunal (as it is not, for instance, in relation to making a bail application). We recognise, and are aware of case-law holding that, a certain level of capacity is required to make an application. For this reason, we are recommending that IMHAs and nominated persons should be empowered and required to bring applications on behalf of a patient who does not apply where there is reason to believe that they wish to do so.

Decision by fewer than three members/paper decisions: the topic group was clear that, given the gravity of the nature of the rights being considered by the Tribunal (and also the 'rule of personal presence' developed by the Strasbourg courts in the context of proceedings concerning detention of those with mental disorder), the Tribunal should make substantive decisions in relation to a patient as a panel of three following an oral hearing, except where the patient has specifically requested that an oral hearing be dispensed with. The topic group, however, considered that case management decisions should be capable of being made by a single judge to secure the most proportionate use of Tribunal resources. Linked to this, the topic group also considered that giving the tribunal the power to make costs orders in respect of conduct would enable the Tribunal to focus the minds of detaining authorities on the need for timely consideration of the justification for detention, as well as to enforce its case management powers.

Pre-hearing examinations (PHEs): the topic group heard from stakeholders, in particular service users and their legal representatives, that they wanted PHEs to be available to patients that want them. The majority of the group (the psychiatrist member and the medical Tribunal member of the group dissenting) considered that was no proper basis to dispense with PHEs, which are compulsory in Wales and are thought to be necessary by the Mental Health Review Tribunal for Wales, and are seen as of importance by patients.

Tribunal membership: the topic group would, in principle, have wished to recommend that either the medical or specialist lay member should be drawn from a pool of appropriately qualified individuals for cases in specific areas (most obviously CAMHS, forensic, learning disability / autism, older people). However, this would be logistically impossible in practice given the small number of specialist psychiatrists. For example, the Tribunal already has a CAMHS panel comprising 110 members. CAMHS cases comprise 3% of tribunal workload i.e. approx. 1,000 applications and referrals per year. There are 110 CAMHS members, and it is not possible for them to be present for every hearing.

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The topic group's recommendation reflects the closest approximation to this goal, which is that the judicial college should develop a system of accredited training for panel members to become 'ticketed' in specialisms including children and young people, forensic, learning disability / autism, and older people. HMCTS would then keep records of their members and allocate them to appropriate cases. This is important in both equality and human rights terms in terms of ensuring that a patient's case is determined by a panel best equipped to consider the particular considerations that may arise in the context of their case. Recruitment and training of members should also extend to include expertise and/or knowledge or experience in race relations and anti-discriminatory practice.

Proportionality of decision making concerning protected characteristics: the Review is looking in particular at the disproportionate number of black men who are detained under the MHA. We were keen to discern what proportion of applications for discharge are made to the Tribunal by BAME patients, and what the comparative discharge rates are. HMCTS and the Tribunal do not collect this information, but we did hear from the Legal Aid Agency that excluding the proportion of unknowns/ethnicity suppressed, in 2017/18, Black, Asian and Minority Ethnic (BAME) account for about 24% of patients that received legal help/ CLR. However, a large number of responses are unknown which may bias the results. We are recommending that information on protected characteristics, and particularly ethnicity, is collected and published by the Tribunal Service on both numbers of applications, and rate of discharge.

Treatment challenges

The Review's interim report set out that there are problems with the MHA's compatibility with the ECHR concerning a patient's rights to challenge compulsory treatment. On a narrow reading of the current Strasbourg case-law, it would be possible to solve those problems by the much earlier use of SOADs in the course of a patient's treatment. However, we are cognisant of the recommendation of the Council of Europe's Committee on the Prevention of Torture⁴³ that a patient should have a right to challenge the administration of a specific medication before the mental health Tribunal. We also note that specifically judicial oversight has long been recognised as important by the (English) courts in the case of compulsory treatment.⁴⁴ However, the current mechanism to obtain that oversight is by way of judicial review to the High Court. In reality this is an ineffective

⁴³ European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment; CPT/Inf (2017) 9. The Government response in January 2018 to this recommendation specifically noted that this Review was underway.

⁴⁴ See eg Hale LJ in *R(Wilkinson) v Broadmoor Hospital, Responsible Medical Officer & Ors* [2001] EWCA Civ 1545

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route of challenge which is very rarely exercised (the group is aware of only one reported case in the last 12 years).

The topic group consider that an effective route of challenge to a court is required as a last resort, introduced in conjunction with other mechanisms to enable earlier resolution of disputes concerning specific medical treatments in the hospital setting, including by way of SOADS (perhaps introducing a tiered approach) and complaints mechanisms administered by the CQC. The court on such a challenge should only – as at present – have the power to determine that a specific medication not be given.

This route of challenge could lie either to a single judicial member of the Mental Health Tribunal or to a judge of the Court of Protection (which would require amending the jurisdiction of the Court of Protection). Which route will depend upon (a) precisely what powers the Tribunal should have upon review of the wider care and treatment plan; and (b) the respective resource burden upon the Tribunal and Court of Protection, both of which will require further consideration and investigation before a final decision can be made.

Hospital Managers

The group heard that associate hospital managers' current role in granting discharge is thought by many to be ineffective, although it also heard from some hospital managers who considered that their discharge function was important. Information we received from 5 NHS Trusts for 2017-18 recorded 86 hospital manager hearings of which 7 resulted in discharge (this compares to 1,215 Tribunal hearings and 105 discharges across the same Trusts). On balance, and informed in particular by the perspective of the service users it heard from, the topic group considered that the valuable – and scarce – resources of associate hospital managers can more usefully be deployed as a body of local representatives to monitor the day-to-day life in their hospital, reporting to the governors of the hospital (or their equivalent in independent hospitals) and ensure that proper standards of care and decency are maintained, including by monitoring the use of seclusion and restraint. They should, further, be given powers to take action in respect of individual patients, either at the request of the patient, or of their own motion, including (1) to require an RC to explain care and treatment decisions being taken in relation to the patient (including as to such matters as seclusion/restraint); (2) require the RC to make a referral to a SOAD; and (3) refer a patient's case to the Tribunal in specified cases, including where the patient lacks capacity to do, or where there are reasonable grounds to consider that there has been a material change of circumstance since it was previously considered by the Tribunal. These powers would enable the associate hospital managers to act as a mechanism to secure effective protection of the rights of patients.

The topic group considered that associate hospital managers should be given a new title (such as hospital visitors) to distinguish them from the managers of the hospital; those managers will need to retain the power to discharge a patient where fundamental errors

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have been made in the admission papers, as a corollary of their functions to receive that paperwork on behalf of the hospital. The details of the appointment of hospital visitors, including who should appoint them, the degree of independence required from the relevant hospital, standards to which they should be held, and the extent to which steps should be required to ensure that they were representative of the community from which the patient population of any given hospital is drawn should be the subject of consultation by government in due course.

Renewals

Late in its deliberations, the Tribunal group had sight of a draft recommendation from the detention criteria group that the s.3 detention periods should be amended to run for up to three months, renewable for a further three months, and at six-monthly intervals thereafter, and that renewals should be by the RC and an AMHP. Taking all the factors into account (including the numbers of those likely to be subject to longer-term detention), the Tribunal group favoured a 12-month renewal after the first six-month period; the Tribunal group was, further, told that it was not practical, on resource grounds, to have an AMHP involved in renewals, even if such would be desirable in principle.

Matters considered but not taken forward

The topic group considered whether changes should be made to the relevant procedural rules to bring the Tribunal in line with the Court of Protection, ie that the default position is that hearings are open to the public, subject to reporting restrictions. In particular given the presumption that the patient will attend, potentially in a state of mental ill-health (and that the personal presence of the patient in a Court of Protection case is a factor pointing to holding the hearing in private), the topic group considered that a change was not warranted at this time; it noted that it was open to any person to apply to the Tribunal for the hearing to be held in public. Nor did the topic group consider that the additional burden of producing written judgments for publication in each case was warranted for purposes of public education about and scrutiny of the work of the Tribunal, which could be achieved by the Tribunal producing more detailed overviews of the nature of cases coming before it. The topic group did not make any recommendations as regards victim impact statements, noting that they could be put before the Tribunal (with a focus on the nature of the patient's condition), and considering that the present system struck the right balance, if properly administered. Finally, and noting the judgment of the European Court of Human Rights in *Seal v UK*, the Tribunal topic group did not consider that amending s.139 MHA 1983 constituted a sufficiently pressing priority to make a specific recommendation in this regard.

4. Implementation of recommendations

All of the recommendations would require legislation, as all would be amending statutory functions discharged by relevant persons/bodies under the MHA 1983. Legislative changes would need to be accompanied by Code of Practice changes. The changes to Tribunal powers and procedures would require secondary legislation to amend both the English and Wales Tribunal rules (accompanied by changes to accompanying practice guidance from the Tribunal judiciary).

Central government will need to be involved, as will HMCTS for Tribunals and Court of Protection and their respective judiciary. Insofar as they require changes in practice on the part of those appearing before Tribunals (including, in particular, responsible clinicians), it will require action on the part of relevant professional bodies (in particular the Royal College of Psychiatrists) to embed new practices.

Funding will be required to resource the additional burdens on the Tribunals and the Court of Protection, and for legal aid (including legal aid to cover additional costs incurred in relation to challenges to treatment decisions). The topic group noted also the impact of the low rates of legal aid upon the quality of representation at tribunal, and the consequential impact of poor quality representation at tribunal upon the experience of patients appearing before it.

We do not expect a large number of additional hearings for the Tribunal as a result of the expansion of powers (because the expansion of powers will be exercised only in relation to applications already before them, ie for discharge of detention, a CTO or a conditional discharge), but we do expect that some hearings will take longer. We also expect that the reduction in periods of detention under s.3 will increase the number of applications for discharge. We also expect that Tribunal may need to recruit more panel members, and this will take time. Additional training will need to be resourced and funded for the specialist ticketing system we are proposing. The Ministry of Justice is not funded to cover these additional costs, and so this may need to be included in an application to the next Government Spending Round.

The recommendations made by the topic group are intimately connected to the work of several other groups, in particular that of the detention criteria, consent to treatment, Criminal Justice System (CJS), CTO and aftercare groups. In particular, precisely what the Tribunal is expected to consider as part of its functions will depend significantly on what are proposed by way of detention criteria. Further, the greater the embedding of decisions about care and treatment (both medical and non-medical) that respects – insofar as possible – patient choice, and the greater the ability of patients to obtain redress for matters concerning them outside the court arena, the lower the workload to be imposed upon the Tribunal and/or Court of Protection.

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These recommendations would directly or indirectly impact upon Wales as well as they will have impacts upon both reserved (justice) and non-reserved (wider health) matters. There will need to be consideration with Welsh Government as to how implementation of these recommendations would impact upon the position in Wales, given the disconnect between the reservation of powers to Westminster in relation to justice and the responsibility for the funding of the implementation of those powers lying with the Welsh Government. The topic group was sympathetic to the particular problems faced by the Mental Health Review Tribunal for Wales arising out of its anomalous position, but was of the clear view that having a two-tier system for Tribunals depending upon physical location would be problematic in human rights terms, especially given the substantial number of patients placed by English commissioning bodies in Welsh psychiatric hospitals.

5. Evidence and analysis

Timescales can drive behaviour. Statistics obtained⁴⁵ from the English Tribunal Service show that

- Approximately 30% of people on a S2 make an application to the Tribunal
- From this sample week, most patients make an application in days 5 – 9. The numbers after day 14 are so small as these applications have to be considered separately by the Tribunal and granted only if reasonable reason to appeal after the deadline of day 14:

Total applications: 202

Day 1-4 No. (%)	Day 5-9 No. (%)	Day 10-14 No. (%)	After day 14 No. (%)
65 (32.2%)	81 (40%)	51 (25.3%)	5 (2.5%)

- English Tribunals stats for 2016-2017 show that 2,200 73% of patients were discharged within 48 hours of a scheduled S2 Tribunal hearing.

⁴⁵ Taken from all receipts in June 2018

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Ethnicity data from legal aid applications: 95% of legal help/ Controlled Legal Representation (claims in 2017-18 were for the patient seeking discharge. These are the client ethnicity figures:

	Legal help/CLR
Asian/Asian British	6%
Black/African/Caribbean/Black British	10%
Mixed/Multiple ethnic groups	3%
BAME total	19%
Unknown or Ethnicity suppressed	21%
White	60%

	Patients that received Legal Help/ CLR
Asian/Asian British	2,152
Black/ African/ Caribbean/Black British	3,755
Mixed/Multiple ethnic groups	969
Unknown or ethnicity suppressed	7,463
White	21,596

Excluding the proportion of unknowns/ethnicity suppressed, in 2017/18, Black, Asian and Minority Ethnic (BAME) account for about 24% of patients that received legal help/ CLR. However, a large number of responses are unknown which may bias the results.

Annex 1: Final opinion of Tribunal working group members on Part V of the Mental Health Act 1983

§1 — INTRODUCTION

This paper lists the revisions to the existing tribunal framework in Part V of the Act which are supported by the tribunal working group.

None of the recommendations has significant resource implications. The vast majority are resource-neutral or resource-minimal. All of them will significantly benefit those people subject to detention or compulsion under the Act.

A separate working group paper contains proposals for more fundamental changes to the tribunal's jurisdiction by giving it new roles different in kind to those it currently exercises.

However, we would not wish it to be thought that the revisions to the existing framework suggested here are less important. Indeed, they may well be more important in terms of bringing about necessary change because they represent the lessons of the last 35 years: the things that practitioners have identified through long experience as legislative weaknesses or limitations that can easily be rectified, so as to give the tribunal broader powers to ensure that people with mental health needs are treated in the most humane and least restrictive way possible.

	Proposal	Why the working group support it
§1 — TRIBUNAL POWERS IN UNRESTRICTED CASES		
1	The tribunal discharge criteria (and also therefore the detention criteria) should be tightened.	The proposal reflects concern that too many individuals are detained or subject to compulsion under the 1983 Act. The requirement that a person's mental disorder must be of 'a nature or degree' which warrants their detention or makes that appropriate was originally a socially acceptable euphemism for "lunatic". It was intended, and at the time understood, to set the level of mental disorder required at a high level. We think that most practitioners and tribunals are no longer aware of the severity of disorder that phrase was intended to convey and that something more akin to a best interests or benefit from admission and treatment approach is applied today.
2	The Act should commence with a set of statutory guiding principles, such as	This will give statutory effect to guiding principles of the kind set out in the Code

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	<p>the principles currently set out in the Code of Practice.</p>	<p>of Practice and require a tribunal to apply them when making decisions about whether to detain or discharge a citizen, eg</p> <p>2. Guiding principles</p> <p>All persons dealt with under this Act shall be cared for and treated—</p> <p>in accordance with the European Convention on Human Rights;</p> <p>wherever possible, without recourse to formal powers or compulsion;</p> <p>in the least controlled facilities possible;</p> <p>in such a way as to promote to the greatest practicable degree their self-termination and personal responsibility;</p> <p>(2) Before a court, tribunal or individual makes any decision under this Act concerning a patient's care or treatment, or the use of compulsion, the body or person in question shall have regard to—</p> <p>the requirements of subsection (1) above;</p> <p>the ascertainable wishes and feelings of the patient;</p> <p>the likely effect on him of any change in his circumstances;</p> <p>the suitability of the proposed care and treatment in the context of his age, gender, sexual orientation, social, cultural and religious background, and other personal characteristics;</p> <p>any harm which he or other persons have suffered or are at risk of suffering;</p> <p>the likelihood of the care or treatment alleviating or preventing a deterioration of the patient's condition;</p> <p>his needs;</p> <p>how capable those caring for him are of meeting his needs.</p>
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3	A tribunal should be required to specify the risks of continuing detention or compulsion,	Some practitioners limit their risk assessments to the harm that is likely if the patient is released. When considering its discretionary power of discharge, a tribunal should be required to record both its assessment of the risks associated with discharge (eg physical harm to self or others) and the risks associated with continued detention (eg loss of family contact, income, employment prospects, liberty, etc). Essentially a balance-sheet approach.
4	The tribunal's discretionary power of discharge should be restored to what was intended, and always was the case, prior to the decision in <i>GA v Betsi Cadwaladr University LHB</i> [2013] 0280 (AAC).	The GA decision was completely at odds with the history of the legislation, the intention of Parliament and the statutory scheme and may have had a significant effect on the tribunal discharge rate. The legislation needs to be urgently amended so as to restore the historic position since 1959 that a tribunal may at its discretion discharge a patient, subject only to the usual judicial review principles, ie a decision to discharge at the tribunal's discretion can only be challenged if irrational, etc.
5	Provided a bed will be available within the next 28 days, in unrestricted cases a tribunal which does not discharge a patient should be able to direct transfer to another hospital with a view to facilitating their discharge from hospital at a later date.	At present the tribunal may only recommend transfer to another hospital. In appropriate cases this will enable a tribunal to direct a patient's transfer to a hospital nearer to their home, to a less secure facility, etc. If a tribunal is sufficiently expert to overrule the responsible clinician by rescinding the section and directing discharge then a fortiori it is also competent to overrule the responsible clinician or hospital managers by directing a relaxation of the conditions of detention or compulsion, eg by directing the patient's transfer or the grant of leave of absence.
6	In unrestricted cases a tribunal which does not discharge a patient should be able to direct that the patient be granted leave of absence.	At present the tribunal may only recommend the grant of leave of absence. A tribunal which is competent to terminate detention is competent to authorise a relaxation of the conditions of detention. Following such a direction, the responsible clinician (RC) would have the same power to revoke the leave of

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		absence and to recall the patient to hospital, and the same power to vary the conditions of leave, as s/he has in the case of a patient to whom the RC has granted leave, provided that s/he acts in good faith and there has been a relevant change of circumstances since the tribunal made its decision.
7	In unrestricted cases a tribunal should be able to direct that the patient be received into guardianship.	<p>At present the tribunal may only recommend reception into guardianship. Guardianship has always been woefully under-used as an alternative to detention or a CTO.</p> <p>Such a power may unleash the potential of guardianship as a light-touch social services-led alternative to detention or CTOs.</p> <p>The tribunal may require the local social services authority to provide a care plan, and must take into account its representations as to the suitability of guardianship, but ultimately tribunal-imposed guardianship as a means of terminating detention would not require local authority consent.</p>
8	A tribunal should not have a power to direct or recommend that a patient is made the subject of a CTO on such conditions as it thinks fit.	<p>A CTO regime is very different to guardianship. A guardian's powers are limited by statute to specifying a place of residence, requiring the patient to attend specified activities and requiring access to the patient.</p> <p>Guardianship is therefore a light-touch order. The statute already provides for detained patients to be transferred into guardianship and extending this power to tribunal does not change the existing framework.</p> <p>CTOs are more extensive, the conditions are not limited by statute and potentially very invasive, the underlying section 3 application remains in force, and there is a power of recall.</p> <p>If tribunals are given a power to impose CTOs, some patients will think twice before applying for a review out of fear that they may end up on a Draconian CTO that will be in force for far longer than the section 3 application to which they are subject. Tribunals will come to be seen by some as part of the state</p>

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		<p>apparatus that imposes compulsion rather than as a court that exists solely to review and terminate infringements of liberty that are not justified.</p> <p>The evidence may suggest that tribunals are quite risk-averse when it comes to CTO regimes (the tribunal discharge rate in CTO cases is 3.4%, ie 96-97% of applications to discharge a CTO are refused). The effect of giving a tribunal a CTO power (or a power of conditional discharge) may be that in future some tribunals will discharge subject to a CTO and recall civil patients who presently they discharge from section absolutely. One could end up with an even larger number of citizens subject to old section 3s and civil powers of recall lasting many years.</p>
9	If CTOs are to continue, tribunals will need much greater powers to terminate CTOs (including an unfettered discretionary power of discharge) and power to vary the conditions of CTOs it does not discharge.	The tribunal discharge rate in CTO cases is 3.4%, ie 96-97% of applications to discharge a CTO are refused. If CTOs are to remain then, given the terms of reference, there will need to be much tighter control over their use and duration.
§2 — TRIBUNAL POWERS IN RESTRICTED CASES		
Section 37/41 cases		
10	Provided a place is available within 28 days, a tribunal should have power to direct that a restricted patient be transferred to another hospital.	<p>The reasons why a tribunal's powers are extremely limited are historical. When the government lost the X case, it was forced by the European Court of Human Rights to empower tribunals to release patients who it considered no longer required detention in hospital.</p> <p>However, it went no further than it was required to do. It did not authorise a tribunal to discharge restricted patients who would still benefit from being in hospital but no longer needed to be detained in hospital; it did not authorise a tribunal to recommend leave of absence or transfer to a less secure hospital; and it did not authorise a tribunal to lift the section 41 restrictions if satisfied they were no longer required whilst continuing detention in hospital under section 37.</p> <p>It is illogical that a tribunal which is authorised by statute to discharge a restricted patient absolutely cannot take</p>

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		many steps along the road to discharge that fall short of this. There is no good reason why a court/tribunal's powers should be less than those exercisable by the Secretary of State or civil servants.
11	Where no bed at another hospital is available within 28 days, a tribunal should have power to recommend that a patient is transferred to a less secure hospital of the kind specified by it.	The tribunal should have a power to reconvene if the recommendation is not carried out. Where a recommendation is not carried out, the effect would be to set the clock running for European Convention purposes. In other words, there would be the possibility of judicial review proceedings or an ECHR challenge if the patient was then detained in more secure conditions than necessary for a very prolonged further period.
12	A tribunal should have power to direct that a restricted patient be granted leave of absence on such conditions as it specifies.	Following such a direction, the responsible clinician and Secretary of State would have the same power to revoke the leave and to recall the patient to hospital, and the same power to vary the conditions of leave, as they have now provided they act in good faith and there has been a relevant change of circumstances since the tribunal made its decision.
13	A tribunal should have the power to terminate the section 41 restrictions if satisfied that they are no longer necessary in order to protect the public from serious harm.	The Secretary of State has this power and the tribunal should have the same powers as the Secretary of State and civil servants. This falls squarely within the tribunal's area of expertise.
Section 47/49 and 48/49 hearings		
14	The functions currently exercised by the Parole Board in respect of section 47/49 patients should be exercised by the tribunal which considers the patient's case under section 74.	It appears that the risk assessment process undertaken by the Parole Board substantially duplicates that undertaken already by the tribunal. This is a considerable waste of money and resources. Even when one allows for the fact that some financial and other resources will need to be transferred from the Parole Board to the tribunal to compensate for that part of the work which is not a duplication, there is an opportunity for considerable financial savings.

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15	Where practicable the medical member of the tribunal in such cases should have significant forensic experience	This recommendation addresses a concern that the medical member in such cases should have significant forensic experience.
16	Consideration should be given to co-opting members of the Parole onto the tribunal	This would require an amendment to the primary legislation.
17	Section 74 should be redrafted in plain English	Many practitioners and patients find section 74 confusing.
Conditional discharge		
18	A conditionally discharged patient shall be absolutely discharged by the tribunal unless the tribunal is satisfied that the special restrictions are necessary in order to prevent a risk of serious harm to the public.	Section 75 allows a tribunal to do one of three things: nothing, vary the conditions of discharge, direct that the restrictions shall cease to have effect. This is too general. The special restrictions exist to protect the public from serious harm and that should be the test for absolute discharge in section 75.
§3 — OTHER TRIBUNAL ISSUES		
19	Invalid applications: Where a tribunal finds that a Part II application is invalid, it shall record its finding and direct the patient's release from detention or compulsion pursuant to that application. This shall not prevent the patient's detention under a new, valid, application.	For many years it has been believed that a tribunal has no authority to discharge a section 2, 3 or 7 application which is invalid/materially defective. In other words it is neither bound to discharge the application and nor does it have a discretionary power to discharge it. The supposed authority for this interpretation is dicta of Ackner LJ in <i>R v Hallstrom and another, ex p W</i> [1986] 1 QB 824. In fact, Neill and Glidewell LJJ expressly refused to follow Ackner LJ on this point and Ackner LJ did not consider the earlier case of <i>Re VE</i> (mental health patient) [1973] 1 QB 452 where the Court of Appeal indicated that a patient held under an invalid application should have been discharged by the tribunal. This recommendation provides a much more cost-effective way of revoking invalid applications than the present mechanism. The tribunal may defer its decision in appropriate cases to enable a new application to be made that complies with the legal formalities.

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20	A tribunal should have no such power in Part III cases.	Part III orders are made by a court and the authority to detain a person subject to a Part III direction is not one which derives solely from the 1983 Act (the individual will be subject to a sentence of imprisonment, remand in custody, etc).
21	Tribunal membership: The statute should include a requirement that judges/legal members of the tribunal (including the members of an Upper Tribunal panel hearing a mental health case) are able to demonstrate suitable expertise and experience as a solicitor or barrister in practice of the application of the Mental Health Act 1983	For economic reasons the current trend is towards generic tribunal judges. While that approach is convenient from an administrative point of view it must come at a cost in terms of the effectiveness and confidence of the judge and their understanding of practice issues. Indeed, the whole original purpose of tribunals was that a conventional court was not appropriate to the particular field because of its specialist nature. There is therefore an argument that tribunal judges should demonstrate experience and expertise in the field, similar to the section 12(2) requirement for medical practitioners. This recommendation was opposed by the tribunal but had the unanimous support of all other working group members.
22	Tribunal rules: Section 78 of the Act, which deals with tribunal rules, should require the Secretary of State and the tribunal to seek to ensure that the tribunal rules are as simple and short as possible, in plain English, understandable by most applicants, and wherever possible encourage informality and flexibility.	There has been a very unhelpful tendency in recent years for mental health rules and procedures to become ever more complicated. The tribunal rules are significantly longer than their predecessor rules. The rules should be drafted so as to encourage informality; keeps costs down by minimising form-filling, directions and interlocutory applications; and enable the rules to be flexibly interpreted and applied to suit the mental health and needs of the patient. All of this is in keeping with the original idea of tribunals.

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Family and carer involvement

Chair: Mark Winstanley, Chief Executive, Rethink Mental Illness

Working group leads: Danielle Hamm, Associate Director, Campaigns and Policy, Rethink Mental Illness; Alex Kennedy, Head of Campaigns and Public Affairs, Rethink Mental Illness

Secretariat: Graham Sale, DHSC

Membership

- John Crichton, Royal College of Psychiatrists in Scotland
- Jeremy Dixon, University of Bath
- Michael Humes, service user and carer
- Robert Lewis, carer and Approved Mental Health Professional
- Megan Reid, service user
- Paulene Samuels, AMHP
- Service User
- Ellie Watkins, carer and Approved Mental Health Professional

In addition to the core members, the topic group may bring in expert contributors for specific issues within the topic, or to test emerging findings.

Terms of reference

Remit

The interim report said the review will consider further:

'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.

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- 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 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.

The group will consider how current inequalities can be addressed in relation to the Mental Health Act, and any recommendations will consider the potential impact upon individuals identifying with protected characteristics under the Equality Act 2010. In particular, the review is seeking to address racial disparities, with a specific emphasis on people of African and Caribbean descent or heritage.

The purpose of this group is to identify potential recommendations the review could make, in relation to the above and to support the review's overarching goals (see below).

The group will:

- Explore Nearest Relative provision and issues around it, including alternative models implemented in other jurisdictions (eg Scotland).
- Consider Nominated Person replacing Nearest Relative, including where the process might sit within the detention pathway, how best to implement it, and how Nominated Persons are selected when an individual lacks capacity.
- Explore how changes to the Nearest Relative can positively impact on current issues with confidentiality, noting that changes to Nearest Relative are unlikely to address all confidentiality issues.

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Timing and outputs

The group will meet formally on two occasions in addition to a range of engagement events.

i. Review point

Additional research requirements will have been identified and commissioned ahead of the midpoint (31 July 2018).

A progress update will be submitted to the review by 20 July 2018.

ii. Final report

The group will produce a short report to the review leadership by 14 September 2018, using the agreed format, setting out key findings for consideration by the Review as they prepare their final report and recommendations to government.

The topic group's work will be supplemented by additional engagement activity.

Interdependencies

- **Autonomy:** the potential introduction of a capacity test for people who are detained; the purpose and implementation of advanced decisions; and the role of SOADs in challenging treatment decisions.
- **Principles underpinning the Mental Health Act:** impact on issues surrounding confidentiality, and exploration of possible solutions in relation to the defined model of Nearest Relative provision.
- **Advocacy:** cross-over with multiple considerations, such as respective roles and purpose.
- **Tribunal, Hospital Managers, Renewals of section:** the role of Nearest Relative in the context of broader safeguards available to patients, including possible additional Tribunal powers in relation to treatment.

Goals set out in the review's interim report

- 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

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- 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

Report

1. Issue

Overview of the topic:

The nearest relative (NR) is a statutory role filled from a hierarchical list⁴⁶ of assumed caring relationships to a person who is detained under Part II (civil sections) of the Mental Health Act 1983 (MHA). Spouses and civil partners are automatically placed at the top of the list, after which children, parents, and siblings follow in that order. There have long been serious concerns that this method of selecting a NR gives no say to the person being detained and that abusive, inappropriate, or simply unknown people can be selected to fill this statutory role.

The NR mechanism serves a number of purposes, though it is explicitly intended to be a safeguard for the detained person. Nearest relatives can:

- Request a Mental Health Act assessment by an Approved Mental Health Professional (AMHP) for their relative, or apply directly to a hospital to admit their relative

⁴⁶ Nearest relatives are defined under s. 26 of the MHA 1983

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- Their consent is required for the admission of their relative under s.3, whether transferred from s.2 or admitted directly under s.3.
- Request a discharge of their relative from treatment in hospital under s. 2 or s.3, from a Community Treatment Order (CTO) under s.17A, or guardianship order under s.23(2) of the MHA.

The primary purpose of these powers is to safeguard the individual who is detained, by ensuring that no one is detained without the notification and right to formal or informal appeal by a close family member. In theory, this helps authorities and the family to be certain that detention is not unreasonable. The secondary purpose (which is implied within the legislation, and highlighted in the current MHA Code of Practice) is to ensure that families and carers are not excluded from involvement in the care and support of their loved one, although the extent to which this happens varies widely.

Normal rules of patient confidentiality apply to people who are detained, which means that information about their diagnosis, treatment, and about how long they are likely to be detained, cannot be shared without the consent of the person. While NRs have the right to be given all information (including otherwise confidential information) that their detained relatives receive, someone who is detained can object to their NR having access to information.

The opportunity

The Review of the MHA gives the opportunity to replace the inflexible choice of a NR with an individually chosen Nominated Person (NP) – an outcome that is overwhelmingly supported by those who have given evidence to the Review. The aim will be for this revised system to give greater autonomy to people subject to the MHA over which relatives, if any, have rights to involvement and access to personal information. We believe this can mean that the best person is more often chosen to fulfil this important statutory role.

In cases where NPs have been positively chosen we believe there is scope for them to have statutory involvement in care planning where patients consent to this. Even in cases where the patient has not had or taken up the opportunity to choose an NP, we believe that a fall-back system can be designed to provide a safeguard more reliably and with greater regard to the patient's own views than the NR hierarchical list. We also believe that people with capacity who are or may be subject to the Act should have a greater say over which of their data is shared with whom, with opportunities for increased information sharing based on patient consent.

2. Findings

Recommendation 1: Replace the Nearest Relative (NR) mechanism under s.26 of the Mental Health Act with a Nominated Person (NP) mechanism

Detailed proposal and rationale:

1. The review received a wide range of evidence in support of removing the NR mechanism as the principle means of selecting a someone with rights to information and involvement in a patient's care, and in favour of implementing a system of nomination in its place. The topic group found this evidence compelling, and proposes the model below.
2. The gold standard for the identification of an NP is a witnessed nomination made with capacity. This would be a standard part of a care planning and/or advance decision-making process before detention for people in contact with community services and who are identified as being at risk. It will be important to identify best practice ways to ensure that nomination rates are as high as possible.
3. As part of the nomination process individuals would be able to
 - nominate a first choice NP
 - nominate a backup NP in case their first choice is unwilling or unable to fulfil the role.
 - decide whether the NP will have additional powers around care planning (details below)
 - record which categories of information they would like to be shared with which people in their lives, including but not limited to the NP(s) (details below)
 - make a positive choice not to have a NP or be selected an Interim Nominated Person (INP), or make clear that certain individuals should not be selected as an INP
4. At the point of detention there will be a capacity assessment for those who wish to select or change a NP. Those being detained who have capacity to make a nomination will follow the normal NP process. Otherwise the INP process will be followed. People detained under the Act who have capacity will also be able to make or change a nomination. The expectation is that nominations made with capacity will be adhered to irrespective of later objections made without capacity.

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5. There would not be a need to get written consent from NPs at the point of (pre-detention) nomination as this could substantially reduce uptake, though it should be recommended and supported where desired.
6. It will be important to ensure that nominations, or information on where to find them, are held in a way that protects confidentiality while being accessible to those who need it. It is likely that any system for recording and storing nominations will also be used for advance decision-making documents.
7. People detained under the Act would only be able to change NP once in each period of detention, unless sickness/death/incapacity of the NP leaves the patient without the safeguard. If lacking capacity to choose at that point, an AMHP should be required to consider appointing an INP.
8. NPs should be able to delegate the role for temporary (possibly time-limited) periods, if that delegation has first been sanctioned by the patient when establishing their choice of NP. Those making nominations should be able to identify who they will accept as a delegated NP (if anyone), or whether they are happy for the choice to rest solely with the NP.
9. Even in cases where there is a witnessed nomination made with capacity, it will remain possible for an AMHP not to contact the NP on the same grounds as set out in current legislation and case law (ie not reasonably practicable, unreasonableness or incapability). This provides a protection against, for example, abusers or those with no interest in a person's welfare being appointed as a NP. Such cases may occur, when there is evidence that the true wishes and feelings of the patient have changed since they made their nomination, for example because their relationship with the NP has changed.
10. There is a concern that relatives are sometimes displaced inappropriately by the County Court for exercising their powers, because the views of AMHPs are insufficiently challenged. We therefore propose that decisions on displacement and appointment of an INP should go to the Tribunal instead of the County Court, as the Tribunal has more specialist knowledge to challenge AMHPs and should have the ability to convene more quickly.
11. Currently, although an AMHP can decide not to contact a prospective NR if that person is inappropriate, the decision to appoint an alternative person ('displacement') must be taken by the County Court. Concerns have been raised that requiring a judicial process for any displacement is too slow and means that patients are left without this safeguard during the initial weeks of their detention, which for many will be the whole time that they are detained. We thought it important to tackle this, while maintaining adequate oversight of AMHPs' decisions.

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12. In both NP and INP cases (for details on the latter see below), we considered a judicial process to be proportionate only when a displacement is contested.

13. Where it is irrefutable that a NP cannot or will not take on the role – for example because of death, incapacity or a clear refusal – and where the patient does not have capacity to make a new nomination, then the AMHP should record this and proceed with the INP selection. In cases where the AMHP has grounds to believe that a NP would be inappropriate, for example because the relationship between the patient and the NP appears to have broken down, the AMHP must apply to the tribunal to appoint an INP.

Recommendation 2: create an Interim Nominated Person selection mechanism for those who have made no nomination

Detailed proposal and rationale:

14. The group considered the recently revised Scottish system, in which there is no default Named Person, if no nomination is made. However, the evidence we received suggested that the NR is widely regarded as an important safeguard and the topic group concluded that with no fall-back selection mechanism many of those who most need the safeguard would be left without it, including people at the point of first detention and those individuals from communities who have least trust or engagement with services. We therefore concluded that the priority should be to develop a fall-back mechanism that works as well as possible, and propose the model below.

15. Where there is no pre-existing nomination made with capacity and where the person being detained does not have capacity to make a nomination (or decides not to nominate someone), it will be the role of the AMHP to identify an INP.

16. On balance, our view was that the INP selection process should give greatest weight to the expressed views of the patient prior to detention, with some limited additional discretion for AMHPs to reduce the circumstances in which patients can be left without a NP. The process for selecting an INP should progress in the order below. The AMHP would only be able to move down the list where the higher-ranking option has been ruled out for reasons of practicability (ie appropriateness, difficulty or reluctance in engaging with the process, unreasonable delay), with reasons recorded.

a) In the relatively rare cases where there is a health and welfare lasting power of attorney (LPA) then that attorney should be the first choice INP

b) Failing this, the medical next of kin (NoK) should be appointed INP

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c1) Our strong preference is that in the minority of cases in which no INP can be nominated from the above, the AMHP would need to show consideration for key people in that individual's life and make a selection accordingly. Clear guidance would outline the characteristics that an AMHP must weigh up in reaching this decision, which could include, living with the person being assessed, providing regular care or support and having a mutual positive regard and meaningful connection. Exploration of potential candidates would need to be proportionate to the situation and must not be allowed to prejudice a timely assessment⁴⁷.

c2) If c1) is judged to be impractical, a version of the hierarchical list could be maintained, potentially with small amendments to recognise, for example, concerns about the position of unmarried fathers. In contrast to the current system, AMHPs would have the power to appoint an individual from lower down the list where higher ranking options have been ruled out.

17. We recommend that where, according to the existing criteria for displacement, an AMHP rules out someone higher up the list, the AMHP should be able to appoint an alternative INP in line with the outlined process. To maintain sufficient oversight of AMHP decision making, where another person with an interest in the welfare of the patient believes that they would be a more appropriate INP, that individual would have the right to apply to the Tribunal for displacement of the AMHP-appointed INP.

18. Though not time-limited, the INP role would be less permanent than the appointment of a NR in the current system or an NP under this model for three reasons:

a) Where an INP is identified during assessment but no detention takes place, the person who has been assessed should be supported to make a nomination when they have the capacity to do so, rather than the INP be assumed current.

b) There is the ongoing possibility that the patient will regain capacity to make a positive nomination if detained.

c) After 28 days detention there will be a requirement for an AMHP to review whether the person selected as the INP is the right person for the role, based on any further information that has come to light.

⁴⁷ Guidance may need to be developed to ensure sufficient robustness of decision-making criteria, particularly given concerns surrounding the potential for legal challenge of AMHP's decisions. Courts/MHTs in considering challenges to the identification of the NP should be required to apply the same criteria.

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19. There should continue to be a safeguard in cases where people have no appropriate person to fulfil the NP or INP role, as those with no relatives to speak for them are most in need of additional protections. The ability of nomination to reach beyond those on the hierarchical list could further reduce the number of people who have no one who could fulfil the role.

20. Where this is not possible, we are minded to recommend that the s.116 role should be taken by an advocate working in a distinct, separately commissioned role and supported by clear statutory guidance. An alternative option would be to strengthen guidance for social workers and others who currently fulfil the s.116 role, which we heard has been piloted in some areas.

Recommendation 3: Base the powers shared by Nominated Persons and Interim Nominated Persons on those of the Nearest Relative, with some key differences

21. Many of the powers for those in a NP or INP role should be similar to those currently available to NRs but with some important differences.

22. The legal right to request a MHA assessment which currently applies to the NR should be decoupled from the NP/INP role. Instead, anyone with a genuine interest in someone's welfare should be able to request an assessment but, as now, there should be discretion for AMHPs about whether it should be carried out.

23. The group had mixed views on whether the NP should have the power to make a direct application for detention of a relative. This right is rarely ever used and is seen by some as archaic but others felt that it has value as a last resort where requests for help have been ignored. If retained, this power could be proactively given to a NP within a nomination, rather than be a default, and should not apply to an INP.

24. We recommend upgrading the right to be notified about a renewal of a patient's detention, extension of a CTO, and transfer from one hospital to another to a right to be consulted.

25. The NP and INP should have the right to discharge a patient on 72 hours' notice, as currently, with the power for clinicians to bar this on grounds of dangerousness. If the review recommends a removal of hospital managers' discharge role it may be that a power to apply to a Tribunal would be sufficient, but we believe it is important not to weaken the ability of the NP to act as a safeguard against inappropriate detention. Nevertheless, we hope that adding greater rights for NPs to be involved in care planning will reduce their perceived need to use or threaten to use this power simply to get engagement from clinical teams.

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26. We believe the review should consider placing a statutory duty on the responsible clinician to notify an NP/INP about s.17 leave, to build on the existing Code of Practice guidance that carers and other relevant people should be consulted. This would be contingent on existing rules around patient confidentiality.

Recommendation 4: Nominated Persons to have a right to be consulted on care plans, where patient has given prior consent

27. The topic group considered evidence that, many carers and patients believe that family members are often not adequately involved by clinical teams and noted that the current powers of the NR are focussed on rights to admit and discharge relatives. We therefore recommend that at the point of making a nomination, a prospective patient should be able to grant a NP greater rights to input on care and discharge planning than is the case for NRs. If the Review proposes statutory care plans, this would be via a right for NPs to have their views formally recorded in the care plan and a duty for clinicians to 'have regard' to this.

28. The group was clear that it is not the role of the NP to make decisions on treatment, both because of the increased burden this would place on relatives and the challenges of substituted decision making for people who have fluctuating capacity. The group also discussed whether the NP should have the power to challenge discharge. While this could help reduce the harm caused when people are released too early or before appropriate support has been put in place, we considered that there could be significant unintended consequences to this power on Trust resources, patient rights and the nature of the NP-patient role.

Recommendation 5: Improve information and support for NPs / INPs

29. We heard from many relatives and people who have been detained that NRs are often poorly informed of their rights and responsibilities. This undermines the strength of the safeguard for patients and leaves families and carers feeling unsupported. AMHPs should continue to have an important role as the first point of contact and to signpost further information. We also recommend that there should be better information and support made available, both to NPs/INPs who are actively undertaking their role and for people who have been nominated as a NP and wish to learn about the role in advance. Several options that we considered favourably in relation to this were a national helpline, e-learning materials and courses run through Recovery Colleges. It will be important to provide information in a way that is accessible to all who need it, including BAME communities.

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Recommendation 6: Give patients greater rights to disclose confidential information to trusted relatives, including through NP nomination process or advance decision-making documents

30. We have seen evidence that under the current system too much information is disclosed to relatives in some cases and too little is disclosed in others. While there is no need to amend the underlying legal basis for confidentiality and disclosure that already exists, we believe that there are ways to improve practice around confidentiality and access to information by strengthening clarity and consent.

31. We support the continuation of automatic access to an appropriate level of information for NP, noting that this will be greater in cases where consent is given by the patient for the NP to have a new consultative role in care planning. Patients will continue to be able to reduce the information available to NPs/INPs to a minimum by withdrawing their consent.

32. We also heard how the current NR system can mean that too little information is shared with loved ones who are not the NR, despite the wishes of the patient for their information to be shared. We believe it should be possible for a patient to record at the time of making a nomination or advance decision-making document which information they would like shared with which relatives.

33. Some people with severe mental illness know that when they are most unwell they are likely to want to restrict the involvement of their relatives because of the symptoms of their illness, and want to avoid that happening. It should therefore be possible for people with capacity - for example, before detention - to put in place a self-binding directive specifying which information should be shared with whom in the circumstance that they are detained and lack capacity.

Recommendation 7: Give patients greater rights to restrict onward-sharing of confidential information by Nominated Persons

34. We have heard concerns from people who have been detained that in some cases NRs inappropriately share information with other family members or more widely, to the detriment of patients. We believe the review should consider whether NPs/INPs should have a duty of confidentiality towards a patient's confidential information, bringing the NP role more formally into line with professionals involved in the person's care. We are aware that if this is a default it may have unintended consequences of inhibiting mutual support within families, so an alternative option could be that restrictions on onward-sharing could be specified within a nomination made with capacity.

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3. Rationale

Much of the rationale for these recommendations is covered within the section on findings above, but there are two key elements that deserve further explanation.

Model for the selection of the Interim Nominated Person

As a group, we discussed a wide range of options for a fall-back where no nomination has been made or where the NP is unsuitable. We considered this fall-back crucial because many of those being detained for the first time will likely have made no nomination, especially those from BAME groups who are most likely to enter the system in crisis.

We found that any potential system has challenges, in particular:

- The inflexibility of the existing hierarchical list means that inappropriate people are often selected when there are better options available. We concluded that no hierarchical list can adequately reflect the wide range of relationships that exist in different families and communities in a diverse society.
- We also considered and ruled out the idea that the default should be a professional role, as this would undermine the involvement of carers and family members, lead to substantial costs and, based on existing experience of s.116, not provide a better safeguard.
- We are also aware that increasing AMHP discretion risks compromising the independence that is one of the advantages of the current NR role and adding complexity to the selection process, with the associated risk of legal challenge.

Our model therefore prioritises the previously expressed view of the person being detained on the analogous issues of health and welfare LPA and medical NoK. In the case of LPA, we consider the roles a close fit, and there are practical benefits in the INP and LPA being the same person.

Although the selection of a NoK is unlikely to have been made with MHA detention in mind, it is likely to be the best statement available to an AMHP of a person's wishes regarding which family member or friend to involve during a medical crisis. Individuals are free to choose anyone as their medical NoK and in doing so may consider the availability of a person, their ability to help in a crisis, the quality of their relationship and issues around confidentiality that are relevant to the INP role. System-wide ramifications resulting from a fundamental shift in the role of previously selected NoK will need to be considered further and the mechanism of implementation refined.

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In the minority of cases where a patient has no nomination and does not have a LPA or NoK, we have offered two options. Option c1 is the group's preferred approach as it takes an individual approach to the very personal question of who the INP should be, via AMHP discretion supported by guidance. If the review considers the level of discretion assumed by Option c1 to be too broad, then our second choice (Option c2) would temper the worst problems of the current hierarchical list by allowing the AMHP to move down the list according to criteria already set out in case law.

Finally, while AMHPs will have somewhat greater discretion to appoint a relative, the fact that far more will have an NP/INP than currently have an appointed NR will mean greater scope to challenge decisions, not least the decision to detain.

Protection for people with no one to fill NP/INP role

Under s.116 of the current Act, people in this situation may have a professional (generally a social worker on behalf of the director of adult services) appointed by the County Court with the duty to visit the patient in hospital and to take such steps as would be expected of the patient's parents. However, many people do not have anyone appointed and those who do often receive little support. There is additionally a potential conflict of interest for local authorities fulfilling this role while also funding support under s.117.

One option suggested to the Review which the group considered is whether advocates are better placed to fill this role. Advocates are commonly appointed as paid Relevant Person's Representatives under the Mental Capacity Act. The group considered how the IMHA role (representing the views and wishes of the patient) differs from the more autonomous, 'best interests' role of the NR/NP and recommended that the role may be best filled by advocates with IMCA advocacy experience that relies more on this approach (ideally in addition to IMHA experience). Questions remain about how this role should be defined which require further exploration, alongside potential resourcing challenges. Whichever professional takes the role, we would recommend that clearer statutory guidance should be made available.

4. Implementation of recommendations

Who needs to be involved?

Central government to change legislation

The implementation of the model requires substantial amendment to s.26 of the MHA. Much of the selection process and accompanying guidance could be introduced through statutory instruments and/or guidance (ie for AMHPs) and created through a power for the Secretary of State to introduce such an instrument.

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Local government – given impact on AMHPs

Local government training and professional development for AMHPs would need to support their use of the new system, with additional support for the inbuilt aspects of AMHP discretion. Guidance and professional auditing would need to encourage AMHPs to avoid risk aversion in their decision-making.

Secondary Mental Health Services

The Code of Practice would need to change. Services should raise awareness of the value of making advance nominations with capacity, if someone is at all likely to be detained under the MHA. Training will be needed to support the increased role of capacity testing and supported decision making for people under the Act. Awareness raising as part of changes to the Code of Practice would need to reinforce the fact that any routine NoK nominations could become quite important in the context of these nominations being used to fill the INP role. Improved support for NPs and INPs would be commissioned by CCGs and/or nationally, depending on the service model used.

Tribunal service

Giving the Tribunal the responsibility to rule where interim nominations are contested would require further changes and guidance.

Mitigations

Using next of kin to select INP

Giving legal weight to the concept of 'next of kin' – which is, as far as we are aware, an undefined concept in UK law – could have wider legal and practical implications beyond the MHA. This requires further legal advice.

Guidance would have to be updated to clarify to those recording a medical NoK that this may have significant implications in the event that they are detained under the MHA, but that a positive nomination would override this. While it would not be practical for detailed information about the INP role to be provided at all the points at which a medical NoK is provided, more could be provided in MH services. Any information would be an improvement on the current system, whereby a NR can be 'selected' unconsciously, for example by a decision to cohabit.

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Added complexity of nomination process

Guidance will need to be robust and clear to mitigate this, though the system is not substantially more complex than the current one, merely different.

Nevertheless, the change could create confusion for family members, service users, and staff (including advocates). The approach will need clear explanation, to prevent family members or carers who are not as involved from feeling excluded. Service users may need additional support from staff or advocates to navigate the new system, including at the point of nomination.

Increased complexity for AMHPs at the point of assessment

Concerns were raised within the group that supporting those with capacity to make nominations at the point of assessment, which would also entail capacity testing, could be challenging in practice for AMHPs. Clear guidance and a simple process would be needed – for example, via a slimmed-down nomination process, which would aim to put the right person in the NP role initially, with the potential to address the full range of options around nomination at a later point.

Increased discretion for AMHPs

Our recommendations suggest that AMHPs should be able to override an INP/NP and select an alternative in certain circumstances without recourse to a judicial process, where this is uncontested by a positive nomination or by someone with an interest in the welfare of the person being detained. Sometimes AMHPs may use their discretion inappropriately, for example by selecting who is less likely to challenge, or that they will incorrectly assess or weigh evidence. In other cases, AMHPs may do everything correctly, but family members or carers may still be dissatisfied.

This would be mitigated by:

- Giving most weight to the view of the person detained in the form of a nomination made with capacity and, in the absence of that, a prior LPA or next of kin.
- Clear statutory guidance.
- Review of INP after 28 days.
- Recourse to Tribunal where the selection of an NP or INP is contested, meaning that there is early access to judicial oversight of the decision.

New role for MH Tribunal in hearing displacement hearings and in duty for clinicians to have regard to NP views on care plans

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This would be potentially mitigated by reallocating funding from County Courts to Tribunals.

It would also be mitigated to an extent by the increased role for nomination, which will reduce displacement applications as fewer inappropriate people will be chosen. Allowing greater AMHP discretion will mean that the judicial proceedings will only take place on contested cases, unlike under the current system.

Partial mitigation would also be provided by giving the option of a single judge hearing displacement proceedings. This would require a change to tribunal rules in Wales.

Interdependencies

- Assessment of a person as lacking capacity to make a nomination implies a greater use of capacity testing, including at the point of assessment
- Built on the presumption of statutory care planning in some form (with tribunal oversight)
- NP nomination process would sit alongside process for advance decision making
- Discharge application power requires maintenance of hospital managers' hearing, or a similarly-strong alternative through the Tribunal
- Further consideration is needed of how the model will work for children and young people and particularly its interaction with parental responsibility

Annex 1: Evidence and sources

The evidence submitted to the Review's Call for Evidence overwhelmingly called for the abolition of the current hierarchical NR list as the primary selection process and for a form of patient nomination to take its place. There was very strong evidence of the problems with the NR selection process, which was frequently described as "archaic" and "badly outdated". People with experience of detention, family members and carers, and mental health professionals from various disciplines gave a wide range of examples of where inappropriate people were serving as NR, and others where patients had no NR safeguard because the default would be unsuitable. The issues raised by individuals and organisations who responded to the review were also highlighted in the academic literature that we reviewed.

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While there was extensive evidence of the problems with the NR list and the value of a nomination model, there was far less detail on what the fall-back option should be for those who had been unable to make a nomination. Most of those that did give an answer to this, whether explicitly or implicitly, drew on the proposal within the No Voice Unheard Green Paper to replace Nearest Relative with a Nominated Person⁴⁸, and to retain the current hierarchical list as a back-up option.

This topic group is not recommending that approach, in part because the substantial difficulties with the hierarchical list that were raised in the evidence that we reviewed. The reality is that a significant proportion of people will rely on the fall-back option—including some of the most vulnerable, such as those disengaged with services or who are entering the mental health system for the first time at the point of detention.

As a result, the topic group's work has gone beyond the specific policy suggestions submitted to the Review and attempted to develop a unique and appropriate selection model to tackle the problems the evidence identified. In doing so we have provisionally tested our initial conclusions with people with lived experience, including ad hoc consultation with the AMHP leads network – yet appreciate the need for further engagement. In particular, there is a need for further evidence around the current use of NoK in medical settings and the potential consequences of using it within a process to select an INP.

At the same time, many respondents - again including people who had been detained, carers and professionals - regarded the NR role to be an important safeguard in cases where the right person has been chosen. Many respondents to the Review's survey, participants at focus groups, and stakeholders, sought a system which would involve carers, families, and friends in the care and treatment of their loved one in a more holistic and person-centred way. This often focussed on additional involvement for carers, better information-sharing, and descriptions of the ways that the system is currently failing.

List of papers

- The Nearest Relative in the Mental Health Act 2007: Still an illusionary and inconsistent safeguard? (2018) The Journal of Social Welfare and Family Law (Forthcoming) Corresponding author: Dr Judy Laing, School of Law, University of Bristol, BS8 1RJ. Email: J.M.Laing@bristol.ac.uk, Dr Jeremy Dixon, Department of Social and Policy Sciences, University of Bath. Dr Kevin Stone, Department of Health

⁴⁸ For example, Agenda, the Law Society, and the British Psychological Society's responses to the Call for Evidence all strongly supported nomination, alongside many others.

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and Social Sciences, University of the West of England. Dr Megan Wilkinson-Tough, Department of Psychology, University of Bath.)

- Survey of AMHP Leads network on NR displacement (unpublished). 'Survey of use of Mental Health Act s29 (appointment of acting nearest relative)', Steve Chamberlain (2016).
- Experiences of the 'Nearest Relative' provisions in the compulsory detention of people under the Mental Health Act: rapid systematic review (Liz Shaw, Michael Nunns, Simon Briscoe, Rob Anderson, Jo Thompson Coon) Exeter HS&DR Evidence Synthesis Centre, University of Exeter Medical School

Other evidence

The survey conducted for the Review found that:

- 'around 22 carers and 28 people with lived experience talked about specific reforms to the 'Nearest Relative' under the Act; some wanted the right to greater information for the Nearest Relative, but most wanted the patient to have the right to choose their own 'Nearest Relative' and for the current rules to be relaxed around this.'
- Both those with lived experience and carers thought that there should always be an offer made to provide some support, advice, and advocacy for carers.
- A significant theme in the accounts of carers (and those with lived experience) is that their views were often not listened to or taken seriously. In the region of 75 carers talk about feeling ignored by the clinical team.

Stakeholder workshops

Significant concern about NR selection and support for nomination emerged from the stakeholder workshops.

Other issues highlighted included:

- Suggestion that advocate could fill s.116 role instead of social worker
- Risk of service users only naming one relative - they may not be available.

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Summary of selected other evidence

Group of AMHPs

- Issue of unmarried fathers where they have had parental responsibility - should be modernised
- The power of discharge is too extreme, and they would instead prefer more rights to be involved with treatment decisions and to have information from the hospital and be consulted.

Medical law academic

Argued against too much AMHP discretion: 'The lesson of the deprivation of liberty safeguards is that is vitally important to avoid a situation where the person exercising these functions is routinely nominated by the detaining authority.'

Professional clinical organisation

'We recommend the review of the Act strengthens the active involvement of family and carers. This could be achieved by services making explicit statements about including family and carers and revising local information-sharing agreements so that family and carers are automatically included.'

Group of forensic social workers

- Patient should be allowed to choose.
- Difficult if they are an abuser/part of delusional system/victim of offending. Should be up to the assessor – should meet criteria.
- Displacement system should be made simpler and need to have access to legal aid.

Individual AMHP

The Nearest Relative identified by MHA s26 is often an estranged family member – if they can't be contacted, they can't be invited to delegate the NR role, so people are frequently left without a functioning NR despite there being another family member who would clearly be suitable to act but who does not qualify on the grounds of care or residence.

Annex 2: Overview of options considered

As initially indicated in the Interim Report, all agreed that the 'gold standard' would be nomination of an NP made with capacity. The options considered by the group consisted for the most part of options about how the role of the NP could be filled where people have not achieved that, for any reason. A number of key issues of debate, upon which the group was ultimately unable to make a clear decision, are outlined below.

Scottish model of no NP where someone has not been positively nominated:

- Scottish model of named persons has positive elements, but rights are not equivalent to those currently offered to nearest relatives under the MHA.
- The group chose to retain existing rights for the NP in England surrounding admission and discharge, contrary to the model in Scotland. This was justified as part of a complete suite of powers whereby the NP is permitted to act in the best interests of the patient, including the most appropriate environment in which the person receives care.
- Given the extended rights in England, the current role of NR is intended in part as a safeguard. As a result, it needs someone to fill it (even if on an interim basis).

Retention of hierarchical list as fall-back option:

Arguments have been put forward in favour of, and against, the current hierarchical list.

- Concerns from the third sector focus on the hierarchical mechanism, rather than the content of the list itself. Therefore a 'pick and mix' approach would be palatable.
- However, the content of the list itself reflects outdated Western conventions of family relationships, therefore not taking account of BAME communities and alternative models of kinship – so needs to be refined.

Best interests grounds of selection for fall-back:

- AMHP colleagues have argued against an unconditional power to allocate the interim nominated person (INP) on best interests grounds because this may leave them open to legal challenge and has the potential to result in a lot of time spent justifying actions.
- Fears have also been raised about AMHPs using their discretion to game the process.
- Consensus that NoK should be an adequate fall back in many cases:

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- However, this would require a wider system shift ie when naming individual as NoK, patient is consenting for individual to speak on their behalf if they do not regain consciousness, are diagnosed with a mental disorder etc.

Fall-back in the event there is no NoK:

- Any subsequent decision will need to be based on AMHP discretion in line with guidance.
- Concern about challenge to AMHPs' decisions can be alleviated if tribunals have access to same information to make choice.

Retention of current s.116 for those without anyone to fill the NP role:

The group agreed retention was necessary but were unsure who is most appropriate to take on this role.

- It was agreed that local authority provision currently is inadequate.
- IMHAs already involved are unlikely to have the right skills – though (external) IMCAs could potentially fill the role.
- State-funded legal representation might work– and not too expensive given s.116 should apply in few cases, as with deputies for people without capacity

Whether the NP needs to agree to take up the role:

There was disagreement about the need for the NP to agree to take on the role versus making the role mandatory (similar to jury duty).

- This is mostly applicable in the case of INP (eg selected by AMHPs).
- A reciprocal understanding/agreement for NP to undertake the role could be helpful in ensuring appropriate persons are selected and act as an appropriate safeguard.
- Conversely, giving the ability for people to decline the NP role may lead fewer people willing to take it on and potential

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Community Treatment Orders

Chair: Claire Barcham

Working Group Lead: Andy Bell, Centre for Mental Health

Secretariat: Esther Horner, DHSC

Membership

- Claire Barcham (Chair) - EDT Manager, London Borough of Islington'
- Andy Bell – Centre for Mental Health
- Professor Tom Burns – University of Oxford
- Dr Jane Carlile – Northumberland, Tyne and Wear NHS Foundation Trust
- Julie Carr - Royal College of Occupational Therapists; South West Yorkshire Partnership NHS Foundation Trust
- Sue Dinham - Camden and Islington NHS Foundation Trust.
- Dr Nuwan Dissanayaka - Assertive Outreach Team at Leeds and York Partnership NHS Foundation Trust.
- Hannah Moore – Service User and Carer Group member.
- Jennifer Nwachukwu – GN Law

In addition to the core members, the topic group may bring in expert contributors for specific issues within the topic, or to test emerging findings.

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Terms of reference

Remit

The interim report said the review will consider further:

- How Community Treatment Orders (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

The group will consider how current inequalities can be addressed in relation to the Mental Health Act, and any recommendations will consider the potential impact upon individuals identifying with protected characteristics under the Equality Act 2010. In particular, the review is seeking to address racial disparities, with a specific emphasis on people of African and Caribbean descent or heritage.

The purpose of this group is to identify potential recommendations the review could make, in relation to the above and to support the review's overarching goals (see below).

The interim report said: We are not persuaded that CTOs should remain in their current form.

To explore: Variations in the use of CTOs across difference trusts; Models in other jurisdictions, including, but not limited to, Scotland and Northern Ireland.

Timing and outputs

i. Review point:

Gap analysis and any additional research requirements by 31st May.

Progress update to the review by 20th July 2018.

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ii. Final report

The group will produce a short report to the review leadership by 14th September 2018, using the agreed format, setting out key findings for consideration by the review as they prepare their final report and recommendations to government.

The topic group's work will be supplemented by additional engagement activity.

Interdependencies

- MHARAC.
- Maximising patient autonomy.
- Discharge, Aftercare and Care planning.

Goals set out in the review's interim report

- 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

Report

1. Issue

As set out in the Independent Review's interim report, the use of CTOs, since their introduction in 2007, has been much higher than anticipated. About 5,000 people are currently on a CTO at any time⁴⁹. The latest MHA statistics also show that 'Black or Black British' people are nearly 9 times more likely to be given a CTO than white people⁵⁰.

In the scoping stage of the review, we heard from many service users and carers that changing CTOs would be the one thing they would do when reforming the MHA, and qualitative evidence suggests that CTOs are very often experienced as coercive and restrictive by people who are subject to them. Unusually for mental health legislation, there have also 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 has been other research, such as before and after studies, some of which, whilst not as methodologically rigorous as randomised controlled trials, have shown more positive results for some people.

The review has also heard from service users, carers and professionals that there are a small number of people for whom CTOs provide a benefit and/ or represent the least restrictive option. Whilst small in number, especially compared to the c5000 CTOs in existence, this has raised serious concerns about the prospect of repealing CTOs. In particular, concerns have been raised around secure patients and the role of a CTO to support step down from s37 (where s41 isn't available to support discharge). Given this, we believe that there will continue to be a need for some kind of coercion in the community, and therefore repealing could see an increased in use of extended s17 leave or Guardianship, which (especially in relation to s17) offers fewer protections. We have also heard from service users who strongly hold the view that it is their CTO which keeps them well.

⁴⁹ CQC (2015) *Monitoring the Mental Health Act in 2015/16* [online]

⁵⁰ To note, after the end of the Topic Group process the latest figures were published which put this at 8 times <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2017-18-annual-figures>

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Whilst we have heard varying views on whether CTOs should stay or go, we have consistently heard concerns around their application, and inconsistencies in their use. There is, therefore, broad consensus amongst those we have heard from or spoken to, that placing limits on the use of these powers, and increasing the safeguards, would significantly improve the experiences of those subject to this framework.

2. Findings

Recommendation 1: CTOs should remain a part of the MHA, but the government should introduce new or enhanced requirements to tighten every stage in the process. The aim being to significantly reduce the number of CTOs, and ensure people only remain subject to them for as long as they are necessary. This would be achieved by using them in a much more targeted way, with improved safeguards.

- a. Require two approved clinicians (ACs) (one of whom must be whoever will be the RC following discharge) to make a request for a CTO. The AMHP must also have met the patient, discussed the CTO with them, and explored the conditions and recall processes before deciding whether to support making an order. The AMHP must also consult both the nearest relative/nominated person and the community team.
- b. Place time limits on CTOs, with an initial period of 6 months, agreed by two ACs and an AMHP. After this, a CTO must be agreed by a tribunal for a further period of six months, before moving to annual applications.
- c. Require evidence to be recorded against all legal criteria when initially requesting a CTO, and when being considered by the Tribunal. Further consideration is needed on whether the legal criteria should be updated (see following section)
- d. Give Nominated Persons⁵¹ the power to object to the making of a CTO.
- e. Require conditions set as part of a CTO to be justifiable on the grounds of clinical benefit.
- f. Enable Tribunals to review CTO conditions.

⁵¹ The group was aware of the recommendations emerging from the Family / Carer involvement topic group around replacing nearest relative with a nominated person

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- g. Commission appropriate advocacy for people on CTOs.
- h. Reform and simplify the recall process

Recommendation 2: If CTOs are reformed, limit the use of s17 leave post discharge to 3months (after which it would need to be agreed by a tribunal) to avoid extended 17 leave being used, when a CTO would be more appropriate.

Recommendation 3: If CTOs are reformed, rename and refocus Guardianship Orders under the Mental Health Act to ensure there are appropriate and robust safeguards in place (such as a requirement that a condition to live in a particular place could only be imposed by application to a tribunal, if the person objected.) Again, the objective would be to avoid incentivising the use of Guardianship over CTOs.

The topic group would also call for further research and much improved data collection to ensure that a better understanding of CTOs and their impact will become available over the next five years. We also suggest research focuses on any evidence of improvement in the quality of people's lives, rather than looking solely at single measures, such as hospital admission. Service user and carer coproduced research, which developed a definition of 'benefit' or 'positive outcome', against which experience could be judged, would be particularly valuable.

3. Rationale

The consistent message the group has heard is that CTOs are being used too often, often without reasonable grounds, that they feel like a punitive rather than therapeutic measure, that there is a lack of understanding about how they should be used (even amongst professionals), that there is very little space for the voice or views of the service user and carer in the process and that once someone is on one it is very hard to get off. However, there are a small number of people for whom CTOs appear to be beneficial and removing/repealing them could put some people at risk. The group agreed, therefore, that the case had been sufficiently made that repealing CTOs would present a risk to this small group⁵².

⁵² It should be noted that this was not a unanimous view. One member of the topic group supports repealing CTOs on the grounds that the RCT's show they do not prevent re-admission, as they were intended.

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The topic group looked at whether it was possible to identify the specific group(s) who benefit from CTOs; this was done largely through an AMHP Leads survey. We heard a very mixed picture, and at times opposing views. For example, some AMHPs said CTOs worked for service users with chaotic lives, whilst others said they did not work for this group. The group took the view that whilst further evidence and research is needed to understand the impact of CTOs and on whom, trying to restrict the use of CTOs to specific groups was not appropriate. The focus, therefore, has been on finding ways in which CTOs can be used in a much more targeted way, where there is evidence that they are needed and that they will benefit the individual. The measures below also reflect that, whilst CTOs can at times be the least restrictive option, they still represent a restriction on someone's liberty and, therefore, the decision to use one and the safeguards around them, should be more on a par with the decision to detain.

These measures are predicated on the assumption that other reforms being proposed through the review are also in place – particularly the enhanced discharge provisions being developed by the Discharge, care planning and aftercare s.117 topic group. These provisions are vital to ensure that CTOs are not being used as an access process to high quality aftercare - the group felt strongly that no one's access to care following discharge should be contingent on the use of a CTO.

1a: Require two ACs (one of whom must be whoever will become the RC following discharge) to make a request for a CTO. The AMHP must also have met the patient, discussed the CTO with them, and explored the conditions and recall processes before deciding whether to support making an order. The AMHP must also consult both the nearest relative and the community team.

The current process requires an RC in the inpatient setting to complete part 1, the AMHP to sign and the RC to countersign. There is currently no requirement for the community AC, who will become the RC for the CTO (where different to inpatient), to be involved, or that the AMHP should meet the person or their support network. This means there is often a disconnect between the professional who is setting up the order and those who will oversee its implementation, and a lack of consideration of someone's circumstances in the community.

We believe that requiring whoever will be the RC for the CTO going forward to be involved in the initial request would improve the planning and implementation of a CTO, by ensuring good communication between ward and community doctors. It will also prevent CTOs being 'rushed', as we heard examples of CTOs being made in haste by hospital doctors, sometimes to free up beds where there are significant pressures on acute wards.

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Increasing the role of the AMHP should ensure that the CTO takes into account how people normally function in the community and that the individual and the nominated person are properly informed about the process, and their rights to object observed (see further recommendation). Ideally, going forward someone on a CTO would have a 'linked AMHP', so that decision making over time is based on a good knowledge of the patient. We have been told on a number of occasions that AMHPs are often, currently, being asked to make (sometimes very nuanced) decisions about people they know little about.

In areas where the RC is operating in both the inpatient setting and in the community, CTOs should still require sign off from two ACs. The group believes that, as with the decision to detain, this is an important safeguard, to have someone else check that there is sufficient evidence that the CTO is necessary at the outset. In addition, whether the Conflict of Interest regulations should apply to this stage of the process, to provide an additional level of protection should be considered. The AMHP survey, and anecdotal evidence, identified that there is a big variation in the use of CTOs, both between and within trusts. Some of this variation is down to the practices of individual RCs. Requiring another AC, and increasing the evidence requirement (see below) should help to address these variations, whilst leaving plenty of room for professional judgement.

The group considered whether the community AC, who would become the RC for the CTO if separate to inpatient, should be required to come in and meet the patient. However, this was ruled out on the grounds of practicality. Whilst this would have benefits, and could be encouraged in guidance, it should not be mandated.

The topic group also recommends that further work to be done on the potential option of requiring the individual to 'agree' or 'consent' to the CTO. Further legal advice is needed on the differentiation and the implications of the upcoming Supreme Court case concerning whether the law currently allows an individual to 'consent' or 'agree' if the CTO's conditions would amount to a deprivation of their liberty.

1b. Place time limits on CTOs, with an initial period of 6 months, agreed by two ACs and an AMHP. After this, a CTO must be agreed by a tribunal for a further period of 6 months, with annual tribunal applications thereafter.

While data about the time people spend on CTOs is poor, it is clear that some of the 5,000 people on them at any time have been subject to them for long periods. We heard from several service users and carers that once on a CTO it is very hard to get off, and the negative impact this can have on someone's independence. We are recommending, therefore, that CTOs are broken up into time-limited orders: starting with an initial six-month period, which would be agreed by two ACs and an AMHP (as set out above).

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At the six-month point, if the RC wishes to extend the CTO, they would need to apply to the Tribunal (supported by a recommendation by an AMHP, who would have interviewed the patient, and consulted the nearest relative/ nominated person), with evidence supporting why the patient currently needed the additional support of a CTO. If agreed, the Tribunal should be asked to reconsider the CTO after 6 months, and then every 12 months. Each CTO application should stand 'on its own', there must be sufficient evidence to support the course of action as in best interest of the patient at this point.

The RC must prove that the CTO is still needed and that there is evidence that it meets the criteria (see below), rather than the tribunal having to prove it isn't. The tribunal would review the evidence submitted against the criteria for CTOs, and should also have regard to guidance in the Code of Practice, when considering this. The burden of proof at each review will shift, therefore, from an assumption that the CTO will continue, unless it is no longer needed, to an assumption that the CTO will end unless there is evidence that it is still necessary. The AMHP would be required to confirm that the nearest relative/ nominated person did not object to the extension/renewal of the order.

Currently, Tribunals play a role when someone wishes to challenge their CTO, which is allowed once during every time period, when a CTO is revoked, and every three years if an appeal has not otherwise been heard. Evidence from members of the group indicates that automatic tribunal hearings after revocation are particularly unhelpful, as the person concerned is likely to have returned to the community by the time that the tribunal meets, with the use of recall seen as evidence of the need to continue with the CTO. By involving the Tribunal at the initial application, at 6 months and then in the 12-month review instead of linking applications to revocation, we believe people on CTOs would be better protected.

In addition, resources could be better focused on applications to consider or renew the order. 'Decoupling' automatic tribunals from revocation could (based on extrapolated figures from the ADASS & NHS Benchmarking survey Nov 2017) cut the number of CTO hearings by over 1000, or about a quarter annually. In addition, we would hope to see the number of appeals significantly reduce, because service users are likely to be more satisfied that there will be additional scrutiny around the decision-making process, and that an external review is already guaranteed. This does, however, see the role of the Tribunal move from a potential role twice in the first twelve months and then once a year, (plus any additional referrals due to revocation) to a guaranteed role at six months, 12 months and annually thereafter, plus the potential for additional applications between formal reviews at the person's request. This could have significant resource implications. Further work is needed to model the potential burden (factoring in a significant reduction in the number of CTOs) and to consider whether these reformed safeguards, would warrant considering a reduction in the right to appeal/ or a tightening of the process to ask for an appeal between reviews.

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The group considered an initial period of 3 months; however, the view was taken that this was too short. The group's recommendation also assumes an improved discharge process is in place, to support transition from the inpatient setting. CTOs should only be used where someone needs a framework over and above this, for longer term stabilisation.

The group also considered whether there should be a maximum duration on CTOs, which would lead to an automatic cut off. This was ruled out because this risked arbitrarily ending something which is benefiting the individual. The requirement to have an independent review every 12 month, and the right to appeal – subject to above – is sufficient.

The group considered whether at the point at which a CTO was initially set, or when being reviewed, the AMHP should recommend or set the duration of the CTO. This was ruled out on the grounds that this puts too much burden on the AMHP and the evidence required to justify this sort of recommendation would be extremely challenging (as experienced by some Best Interests Assessors). A standard time scale of an initial 6-month period, then 6 months, followed by 12 month reviews for all was identified as preferable.

1c. Require evidence to be recorded against all legal criteria when initially requesting a CTO, and when being considered by the Tribunal. The Tribunal should also have regard to guidance in the Code of Practice when considering CTOs.

This reform is needed to ensure that there is a strong rationale for someone to be put on a CTO, and tackle the practice we have heard around CTOs being used to free up beds or due to risk aversion at discharge. As set out above, this also aims to standardise the evidence threshold to put someone on a CTO, and address the variation in practice across trusts and clinicians.

In line with other areas of reform being put forward by the review, we also believe requiring the documentation of the decision-making process will help tackle the disparity between different groups.

The group, and the call for evidence, identified that a preference for a CTO to be justified there must be evidence that someone has previously disengaged with services, and that if this happened it will have a detrimental impact on their mental health. The group did not reach consensus on how to achieve this. Further work is needed to reach a final decision on following options:

Change the criteria in legislation, to make prior disengagement more explicit, and require evidence to be provided against the new criteria at each application

Keep the current criteria, but change practice by requiring evidence to be provided against legal criteria at each application

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In addition, we would include a stipulation that (except in rare cases, which would need the agreement of a tribunal, most notably under Part III) no one is placed a CTO following their first period of detention under Section 3.

1d. Give Nominated Persons the power to object to the making of a CTO.

This recommendation assumes that the current nearest relative provision is replaced with a Nominated Person, and a strengthening of their role in the MHA system. The group believes the NP should be consulted when a CTO is being requested and review, and that they should be able to object.

Further work is needed on when in the process this would be possible (at any point or only at application to the Tribunal), how this fits with the wider role of the NP, and what would happen if the NPs objection unreasonably delayed or prevented discharge. In line with the current position on s3, this could include the potential to ask a court to displace a NP, if their behaviour was unreasonable in this regard.

1e. Require conditions set as part of a CTO to be justifiable on the grounds of clinical benefit.

We have heard examples of CTOs containing conditions which limit an individual's freedom without evidence that they are necessary or proportionate. We have even heard about conditions being set which reflect the personal views of the RC (for example no consumption of alcohol being a condition for everyone they put on a CTO). While clinicians widely hold the view that they need the freedom to set conditions case by case, this reform would require a higher level of proof that conditions will be likely to benefit the person clinically (as part of their Treatment Plan), and any restrictions imposed would be proportionate to the risks that would otherwise occur. This would need to be evidenced when the CTO is initially being set, and when an application is being made to the Tribunal, and when a new application is being considered.

1f. Enable Tribunals to review CTO condition.

As part of the tribunal application process, the RC would also need to present evidence for the use of conditions they wished to impose, thus allowing Tribunals to review and challenge the use of specific CTO conditions, if they did not feel the appropriate evidence threshold had been met.

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This would add a further safeguard against the use of conditions that limit unjustifiably people's rights. Currently Tribunals can only rule for or against the continuation of a CTO; this would allow them to remove certain conditions where they are ruled to be unnecessary (ie not of clinical benefit, or disproportionate). The tribunal would only be able to review conditions, and the evidence presented by the RC to justify it. The tribunal would not be able to recommend or set conditions.

Further work is needed to decide:

- Whether or not the Tribunal should be able to strike through a condition if they were not satisfied that there was sufficient evidence it was justified.
- Whether a tribunal can seek further evidence or justification from the clinical team.
- The detailed process requirements for each time the Tribunal is asked to consider making a CTO, including whether an 'overlap' period is needed where some conditions will be suspended but can remain until the RC and team have assessed risk and proposed new conditions
- How to ensure RCs maintain sufficient flexibility to enable them to change conditions to reflect the needs of the person over time, whilst still protecting the person from inappropriate conditions.

The group recommend making it a requirement that the AMHP speak to the person prior to making an application to the Tribunal. However, what the process should be if the AMHP finds the individual does not object or is happy for the CTO to continue, needs to be thought through (suggestion is a paper based review should be possible), as does whether or not the person is required to attend, or can nominate someone to attend on their behalf -this should be in line with the tribunal process for other areas of the MHA.

1g. Commission appropriate advocacy for people on CTOs.

The beneficial role of advocates, and importantly appropriate advocates, has been raised throughout the review. This recommendation aims to ensure that those on CTOs are also able to access appropriate support. Most IMHA services are based in hospitals and many struggle to reach out to people on CTOs. This reform would require IMHA services to take proactive steps to offer their support to people on CTOs and assist them to challenge their orders or conditions, for example in preparation for Tribunals.

In line with the review's other recommendations in this space, this has implications for the cost and commissioning of advocacy services. The group believes this could be potentially be offset by improvements in patient experience.

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1h. Simplify the recall process and ensure the process is understood by service users, carers, NPs and professionals

The current process of recall can be slow, cumbersome and unclear. Many service users are unclear about why and how they can be recalled to hospital during a CTO (adding another level of coercion to CTOs in the way they are experienced). We have heard that the threat of recall is frequently used to get people to take medication, as there is a misconception that this alone can justify recall, rather than there also being evidence of a decline in someone's condition.

When people are recalled we have also heard that there can be long delays in the process, for example in sending out notices and finding a bed in the hospital to which they need to be recalled. Whilst there is a need to improve the process, professionals cite the ability to recall quickly as a key benefit of CTOs, especially if they can bring them in before someone's condition seriously deteriorates.

Further work is needed on this, but potential options include:

- Providing clearer information to patients and NRs/NPs about when, why and how recalls will be made
- Ensure patients understand their conditions and recall rules
- Enabling a recall to be made to the place most appropriate for the person and their circumstances. For example, enabling someone to be recalled to a Health-Based Place of Safety to avoid waiting for a hospital bed to become available (this could also help avoid unnecessary admissions if on recall the person is judged not to need further inpatient care). This should be discussed with the patient at the point of discharge onto the CTO. Currently recall must be to named hospital. This may not be the best place for the person (it may be impractical or not somewhere the person would choose to return to). However, further work is needed to consider what criteria might need to be used when deciding what the 'best' place for the might be. (This could also be subject to tribunal overview)
- Change Code of Practice guidance to make it clear that a request for a bed for a CTO patient should be treated with equal urgency to a request for urgent admission in other circumstances. This aims to avoid someone on a CTO being left waiting in the community because they aren't yet 'ill enough' compared to other clients

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Overall, the package of reforms set out above aim to significantly limit the use of CTOs, by increasing the threshold at every decision point to ensure that it is a rigorous, evidence based, process. Whilst there are resource implications around requiring additional checks and balances, the topic group believes these are necessary, and are appropriate, for a process which limits someone's liberty.

Whilst we don't have any proposals relating solely to BAME communities, the topic group believes that the measures above will help challenge the current practices around CTOs, and see them curtailed. The requirement to properly evidence the rationale for the CTO, and for this to be subject to independent scrutiny, should help ensure that biases (whether unconscious or otherwise) are challenged. Better data collection on ethnicity, as being recommended by other topic groups, will also allow, over time, for the use of CTOs among all ethnic groups to be monitored.

Recommendation 2: If CTOs are reformed, limit the use of s17 leave post discharge to 3 months (after which it would need to be agreed by a tribunal) to avoid extended 17 leave being used, when a CTO would be more appropriate.

As set out above, we have heard that some areas are using extended s17 leave instead of CTOs. If the recommendations set out above have the desired affected of limiting the use of CTOs there is a risk that this could lead to increased use of extended s17. If CTOs are reformed, the group also recommends limiting s17 leave to a maximum period of 3 months, without agreement of a tribunal. The RC would need to make the case to the tribunal that nothing short of an extended s17leave, including using a CTO, would be sufficient.

The group considered requiring an AMHP to be part of the process to apply for extended s17 leave, however, this was ruled out as felt the RC would know the patient better.

Recommendation 3: If CTOs are reformed, rename and refocus Guardianship Orders under the Mental Health Act

In line with s17, putting the brakes on the use of CTOs could lead to the use of other coercive measures. 'Guardianship' as a concept is generally considered to be overtly paternalistic and inappropriate in modern society. However, for some adults and young people whose capacity or competence to make decisions is compromised, it provides a framework for the provision of socially & psychologically based support for mental distress/disorders, with the opportunity to appeal, where the person is unable or unwilling to otherwise consent to it. To ensure any additional use of Guardianship was appropriate, the following legislative changes should be considered:

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- The current minimum age of 16yrs should be removed, to ensure it is available to all who might benefit from it.
- The ability to transfer onto Guardianship from section 3 (or vice versa) should be removed.
- The authority to require a person to reside in a particular place, and be returned if they absent themselves without agreement, would need to be authorised by a tribunal if the person objected.
- The order should be renamed as 'Authorised Community Support'

4. Implementation of recommendations

The recommendations set out above would require changes in legislation, changes in chapter 29 of the Code of Practice and additional funding to implement. The most significant additional extra costs would be the role of the tribunal, (which might be offset by changes to automatic referrals and an overall reduction in CTOs) and the need for additional AMHPs available as 'links' to someone on a CTO. This will need to be considered alongside the review's wider recommendations on their role.

Pressure on AMHPs could be reduced by making changes to the s136 requirement that anyone on a s136 (unless judged not to have a mental disorder) must to seen by a AMHP. Instead, if the person could be seen by nurses, OTs or other appropriately qualified mental health professionals (unless admission under the Act is indicated) this would significantly reduce the burden on AMHPs without affecting the outcome for the person. Last year's ADASS 'snapshot' of AMHP assessments found those on s136 were much less likely (@31%) to need admission under section, compared to those seen in A&E informally (@72%) who had already been triaged by other MH professionals. 333 s136 assessments were recorded by 84 local authorities over the two weeks. If this number is extrapolated upwards to cover all 140 English local authorities, over a 12month period approximately 14,400 people under s136 were seen. If half of these people could be seen by others (because they didn't need to consider admission to hospital) the reduction in AMHP assessments could contribute towards the increased AMHP work load in other areas.

As part of the implementation, the review should recommend that the required statutory paperwork around CTOs is revised to ensure that it provides the appropriate safeguards without being overly burdensome. We have heard on numerous occasions that the administrative processes around CTOs are overly bureaucratic. The reforms above will require a substantial change in process, when implementing these changes careful consideration should be taken of the paperwork to support this. As well as improving the process for professionals, the paperwork can also play a vital role in embedding the

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reforms in the day to day. This includes the documentation of evidence and decision making, allowing this to be scrutinised. Revised paperwork should also embed the wider review recommendations on recording characteristics of the patients.

The review should consider whether setting out the treatment someone requires when in the community in the original application would be appropriate (though it should be clear in the paperwork and information provided that a CTO does not allow for forced treatment). The rationale for this is to increase transparency, and ensure there is clarity about what treatment is needed, that necessitates the ability to recall the person if they stop taking it, and there is a resulting decline in their mental state.

A concern has been raised around the lack of understanding & experience of how CTOs should work within the wider mental health community/ system. This includes with Tribunal members. We would recommend that clear guidance and training is provided to tribunals on the role of CTOs.

Further work is needed to identify the potential cost implications of the recommended reforms, and the likely reduction in the total number of CTOs as a result of these recommendations.

5. Evidence and analysis

16-Apr-18 [Draft]	DHSC	Data analysis	Analyst Pack: Summary of data analysis by NHS Digital and MoJ
29-Mar-18 [Draft]	MHPRU	Systematic Review and data analysis	'Systematic review and meta-analysis of all evidence for effectiveness of CTOs (trials and non-randomised studies)'
Forthcoming	University of Brighton	Quantitative analysis of local and national data and Qualitative analysis of service user and carer interviews	Social Factors, Care and Community Treatment Orders. Service user and Practitioner Perspective

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May/ June	Topic Group	AMHP Leads survey	Survey sent out through the AMHP leads network asking
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Discharge, care planning and s117 aftercare

Chair and Working Group Lead: Mark Trewin

Secretariat: Esther Horner

Membership

- Jaswinder Basi - Nottinghamshire Healthcare NHS Foundation Trust
- Cath Gormally – South London and Maudsley NHS Foundation Trust
- Michael Henson-Webb – Mind
- Leigh Hogan - West Berkshire, TBC
- Alan Simpson - Centre for Mental Health Research, University of London
- Service User
- Mark Trewin (Chair) – Bradford
- Nicky Yiasoumi - NHS England

In addition to the core members, the topic group may bring in expert contributors for specific issues within the topic, or to test emerging findings.

Terms of reference

Remit

The interim report said the review 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. This will include:
- The need to modernise section 117 aftercare in relation to the provisions of the Care Act.

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- 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 to any proposed reforms.

The group will consider how current inequalities can be addressed in relation to the Mental Health Act, and any recommendations will consider the potential impact upon individuals identifying with protected characteristics under the Equality Act 2010. In particular, the review is seeking to address racial disparities, with a specific emphasis on people of African and Caribbean descent or heritage.

The purpose of this group is to identify potential recommendations the review could make, in relation to the above and to support the review's overarching goals (see below).

To explore: Best practice examples, and delivery on the ground, of integrated care systems and the findings of the National Collaborating Centre for Mental Health (NCCMH) recommendations on care planning.

Timing and outputs

i. Review point:

Gap analysis and any additional research requirements by 31st May.

Progress update to the review by 20th July 2018.

ii. Final report

The group will to produce a short report to the review leadership by 14th September 2018, using the agreed format, setting out key findings for consideration by the Review as they prepare their final report and recommendations to government.

The topic group's work will be supplemented by additional engagement activity.

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Interdependencies

The Topic Group will need to work closely with the Maximising Autonomy, CTOs, Advocacy and Procedural Safeguards Topic Groups.

The group will need to consider how to incorporate the opportunities and reforms identified in our consideration of 'advance planning' (as led by the Maximising Patient Autonomy Topic Group) to any proposed reforms.

Goals set out in the review's interim report

- 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

Report

1. Background

The process of being detained under the MHA, even when carried out with the upmost regard for a patient's dignity and safety, can be extremely disruptive. The period immediately after discharge from inpatient wards is extremely risky, with a significantly increased risk of suicide in the first few days⁵³. Housing, welfare benefits, childcare arrangements and work can all be disrupted by inpatient care. Getting the discharge process right, and ensuring a service user has sufficient support and access to services in the community to support discharge, meet longer-term needs, and prevent re-admission is therefore critical.

Good Practice guidelines state that discharge planning and care planning should start soon after admission and be a multi-agency process organised and delivered under the Care Programme Approach (Crisp Report 2016; Modernising the CPA 2008). However, service users widely report poor experiences of being discharged⁵⁴, often without notice, without adequate aftercare or community services in place, without community services being notified and in some circumstance in the middle of the night or without secure accommodation. Anecdotal reports suggest that pressure on beds, lack of integration or available community services are drivers of this practice⁵⁵.

S.117 aftercare was introduced in the 1983 MHA to support people by providing a statutory right to care following discharge, and was amended by the Care Act to include ongoing care to avoid future hospital admission. This must be jointly delivered by NHS and Social Care services and cannot be charged for. However, as set out in the interim report, in practice, s.117 aftercare is ill defined, complex to set up and administer, with differing responsibilities and rules affecting Clinical Commissioning Groups and Local Authorities and widespread confusion about its use. The funding issues are complex and tend to dominate the debate about this issue, and can get in the way of delivering what should be integrated care and support. There are circumstances where time and money is wasted seeking clarity about which organisation is responsible for which costs. Case law and guidance developed over the years has added to this complexity. The consequence of this

⁵³ Walter et al (2018) Suicide Methods and Specific Types of Accidental Death and Fatal Poisoning Among Discharged Psychiatric Patients: A National Cohort Study. *Journal of Clinical Psychiatry*

⁵⁴ Mind (2017) Leaving hospital: briefing on discharge from mental health inpatient services.

⁵⁵ As reported through submissions to the call to evidence and wider engagement activity.

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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.

The service user and carer survey also highlighted that the duties under s.117 are not always being met, or that service users and carers have had to push to get access to this provision. The submissions from both local authority and NHS mental health services to the 'call for evidence' clearly outline the level of complexity and frustration for professionals.

There are also concerns with the current system of care planning under CPA and this is currently under review by NHS England. The CQC regularly reports that care plans are of variable quality and are not always shared with service users, in 16/17 3 in 10 (32%) records showed no evidence of patient involvement in care planning, a continuous increase over the last 3 years⁵⁶. We have been told that service users are not being supported to make decisions about what their care plan should look like. The interface across the full range of rights to post discharge support, such as the Care Act, Continuing Health Care and Personal Health Budgets, is also very variable and often dependent on variable levels of local partnership working.

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 multiple care plans to cover different legal frameworks or local guidance to meet their needs. 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.

The information received from the many groups and individuals who have submitted views to the review has given the impression that the complexity of s.117 and care planning, and their interaction with multiple legislative frameworks, organisations and funding streams means that many of the professionals engaged in this process lack the legal literacy to navigate the system and get service users the support and services they have a right to, and it is not sufficiently covered in training.

The Discharge, care planning and s.117 aftercare Group leads have worked with many of the other topics groups to try and ensure that there is an effective interface between care planning and advocacy, advance statements, community treatment orders and many other

⁵⁶ CQC (2018) Monitoring the MHA

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areas. We have also liaised with the Green Paper team at DHSC and the Community MH Framework team at NCCMH who are all working on this.

The aim of the group is to develop the right to care planning and discharge planning so that it is more effective, more equal, fairer and less complex to administer, and we should measure our success against these aims.

2. Our findings and recommendations:

The topic group has focused on setting a vision for what a good, modern, care planning, discharge and aftercare model should look like, rather than simply trying to fix or upgrade the current model. We want a new improved version of aftercare and care planning.

Achieving this has been very complicated and we have been fortunate in having some of the leading experts on these issues on the group or feeding into the discussion. We recommend changes to the law where necessary, but also make recommendations about how existing legal and organisational structures can be improved. However, the group recognises that many of the issues it has been considering are often based on poor quality implementation and regional variation in service quality, rather than necessary legal issues. In addition, addressing this they will require organisations to work across boundaries.

We particularly want the Green Paper for Social Care team based at DHSC to look at these issues, in consultation with service users, as they have a very specific opportunity to simplify and modernise the organisation and funding arrangements of care for people with Mental Health issues. Their actions may mean that some of these recommendations do not need to be within the MHA.

Care Planning and Discharge Planning

Summary of recommendations in this section:

Recommendation 1: S.117 should continue as a free-standing right for those detained under eligible sections of the MHA

Recommendation 2: There should be a statutory framework for assessment, support planning and review of support provided under s.117, which should integrate with the Statutory Care Plan and Intensive Discharge Support Plan (see below)

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The group felt strongly that s.117 provision should remain as a freestanding right for those detained under eligible sections of the MHA. In the current environment s.117 is an important way in which people who have been sectioned under eligible sections get the long-term support they need, free of charge. There was some discussion around making it a 'gateway' provision to existing provision under the Care Act, CHC and/or personal health budgets. However, this was strongly voted down as there was a concern this would lead to a reduction in the provision of services for those eligible for s.117 aftercare, and potentially subject to means testing. Instead, the view was that this concept of a 'gateway provision' should be taken forward under a new Statutory Care Plan, with a single document encapsulating a service user's care and support in entirety (see below).

S.117 is critical to the concept of reciprocity – and the group feels strongly that there is a case for those detained under the MHA to have access to assessment, additional support and services, to support people back into the community, to meet ongoing mental health related needs and to prevent deterioration leading to readmission.

The group felt that s.117 needs a statutory framework so that individuals get a proper assessment and a clear care plan. While s.117 provides a joint duty to provide services it does not give clear duties to assess in a timely manner or to review the support arrangements. While the Code of Practice requires that all eligible patients receive a written aftercare care plan, information from service users suggests that this doesn't happen in too many cases⁵⁷. Without a clear framework s.117 support can be lost among other statutory and non-statutory entitlements. We would like to see:

- A duty for a multi-disciplinary approach to identify inpatients' needs under s.117 in good time prior to their discharge, with the patient at the heart of the process and fully involved in the process
- A duty to provide a patient with a co-produced written aftercare plan prior to their discharge which sets out services which are to be provided under s.117.
- A statutory duty for a multi-disciplinary review of a patient's aftercare plan at least annually or as circumstances require

⁵⁷ Mind (2017) Leaving hospital: briefing on discharge from mental health inpatient services.

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Recommendation 3: There should be a **Statutory Care Plan** for anyone in need of secondary or community mental health services.

There should be a **Statutory Care Plan**, which underpins support for anyone in contact with secondary or community services. The Statutory Care Plan, should be personalised and co-produced and support access to all available rights and services. This recommendation takes what is currently based in guidance, and makes it a statutory right. This is because the group felt strongly that 35 years of guidance based care planning had not delivered the care plans or the support services that people should expect. We recognise that there are a range of organisations and researchers (NCCMH, NHSE Personalisation team, NHSE Transforming Care Team and EQUIP etc.) working hard to change this, but we do not feel that more guidance is sufficient, and our recommendations will help embed good practice.

The statutory care plan should be a single document which can be used across responsible agencies, and should wrap around existing care planning provision. This can be very basic or very complex. We recognise that this is an aspiration of the Green Paper for Social Care and we welcome this. The statutory care plan should function as a tool to access and record all the relevant elements which are to be provided by the Care Act, personal health budgets, Continuing Healthcare or community MH services and should explicitly outline these. In addition, any legal right to advanced statements could be included in the care plan. This should always be co-produced and a copy given to the patient. This statutory care plan would include and indicate support provided under s.117. This would be set out in **Intensive Discharge Support Plan, and be incorporated into the Statutory Care Plan.**

The Welsh statutory care plan is a useful model for this recommendation.

Recommendation 4: There should be a new, time limited, Intensive Discharge Support Plan, for anyone being discharged from an inpatient setting.

We recommend that **all inpatients** should have an **Intensive Discharge Support Plan**, which expands upon the general right to a statutory care plan. Preparation for this should start immediately upon admission. This recommendation reflects the evidence that admission and discharge to hospital are usually times of great stress for people using services and that they will have greater needs or practical assistance and intensive support upon discharge. Admission can cause disruption to housing, work, paying bills, childcare etc. There is no clear responsibility at the moment to require public bodies to keep a person's life stable to assist discharge. This plan will ensure the appropriate multi-agency discharge arrangements are in place and will link to the statutory care plan and any inpatient treatment plan adopted.

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The duration someone is on this Intensive Discharge Support Plan will vary, depending on need. At the point of discharge the Statutory Care Plan would be revised, to reflect current care needs and an individual's experiences and care whilst an inpatient. The Intensive Discharge Support Plan would sit within the overall Statutory Care Plan and set out the additional support and care required for the period after detention. Someone will remain on the Intensive Discharge Support Plan until they are ready to step back down to the Statutory Care Plan.

We feel that these provisions can also be developed to be used as a least restrictive alternative for discharging people from hospital and this will support a reduction in the use of Community Treatment Orders.

Interaction with s.117

The Intensive Discharge Support Plan process aims to ensure that no one leaves hospital without a well-planned discharge process and improved access to services. As set out above, the aim of the plan is to identify the additional care and support needs in this period, and support service users to transition back into the community after being an inpatient. The current s.117 aftercare provision has a longer-term provision, not tied/limited to disruption caused by detention, which provides for on-going care and support to prevent deterioration and re-admission. For those entitled to s.117, we would expect the IDSP to set out the provisions and services eligible under s.117 and to last, in line with the current provision in legislation, until *'the person concerned is no longer in need of such services'*.

Funding issues

Summary of recommendations in this section:

Recommendation 1: The Topic group wanted to make a clear recommendation that we think the Government should make **social care free at the point of delivery**, as is the case with the NHS. We recognise that this is outside the scope of the review and so the rest of the recommendations assume this is being looked at by the Green Paper team.

Recommendation 2: The support provided for people detained under any part of the MHA and discharged via the Intensive Discharge and Support Plan should not be subject to any LA charges. For those leaving a shorter section, or an informal patient, this would be for a time limited period. For those eligible for s.117, this would last until it was deemed the person concerned is no longer in need of such services

Recommendation 3: For those not eligible for s.117, this limited time should reflect the duration of someone's time in hospital and level of need. Government will need to consult further on this

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Recommendation 4: There should be a **single funding pot** for the provision provided by the NHS and LA under the Intensive Discharge and Support Plan (including s.117), to reduce conflict and complexity about shared decisions around care and support. An option to be explored further would be the concept of a 50:50 split for this pot.

Whilst ideally, services to all vulnerable people with a mental health problem and eligible for care and support would be free. We recognise that this is not currently Government policy. We therefore accept that this will not be a core recommendation. However, under current rules means tested LA provided care is free for those coming off sections eligible for s.117 aftercare. This creates disparity in the system. Individuals with potentially comparable long-term needs are getting different levels of care and being charged differently, dependent on whether or not someone has been detained, and if so, under what section. As set out above, the group feels strongly that s.117 should remain, and there should be additional support for anyone leaving hospital. However, the recommendations (and options considered by the group) aim to try and find a way to rebalance this position, whilst not having a detrimental impact on those who currently receive s.117. The simplest way to address this would be to make all care, support and medication free of charge to individuals with SMI, regardless of whether delivered by NHS or LA services or whether or not someone has been detained. However, we recognise that this is not possible within the current economic/political environment.

We propose that free care, for detained patients, should be linked to **the Intensive Discharge Support Plan**. Everyone discharged on this plan would get free care, this includes people on long term and short-term sections of the new MHA. We have not included informal patients in this. We recognise that this could be difficult in the current economic climate, however the group believes that the principle of reciprocity for those who have detained should apply to all sections. However, how long service users have free provision would vary.

There should be **review procedures built into the new IDSP, which reflect the nature and duration of someone's time in an inpatient ward**. For those on a short section (or informal patients) the expectation is that free care ends after a specified period (discussions with service users suggested around 12 months for s.2). For those coming off a longer section, and eligible for s.117, the expectation should be that this lasts until *'the person concerned is no longer in need of such services'*. The expectation is that s.117 aftercare and support will continue unless there is a clear evidence base and agreement with the service user that it is not needed. We are clear that service users should not have to fight to keep this right – it will be assumed to continue unless clearly not necessary. However, we want to ensure that all service users have their needs regularly assessed, to ensure they are getting the provision they need. This will help ensure all people with a mental health issue have fair access to regular review of their needs. The duration should match need, and the group is clear that for some people this may last a lifetime. Once

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someone is no longer in need of the services provided for under the IDSP (whether on the shorter plan or longer-term s.117) they would step back down to the Statutory Care Plan.

We recommend that health and social care services in each area should have to **set up a single joint funding pot** to cover services identified as part of the Intensive Discharge Support Plan (including services provided under s.117), which should be free. We recommend that the Green Paper and Long-Term Plan should consider these issues in consultation with service users. We have debated as to whether this should be set at 50% or set regionally.

Content of care plans and Intensive Discharge and Support Plan

Summary of recommendations in this section:

Recommendation 1: There should be a **clear statement in the Code of Practice** of the purpose of the statutory care plan and the Intensive Discharge and Support Plan.

Recommendation 2: Government should **consider making prescription charges free for people on long term psychiatric medication.**

There should be a clear statement within the Code of Practice guidance as to the essential criteria within the statutory care plan and the intensive discharge plan, and a definition of the purpose of post hospital aftercare and, in line with the amended definition in the Care Act, s.117 aftercare. Government should consider making prescription charges free for people discharged from detention and possibly for all people managing long-term mental health conditions. We are currently working with NHSE on this issue and the current arrangements for prescription charges.

Organisation/infrastructure issues:

Summary of recommendations in this section:

Recommendation 1: There should be a **statutory responsibility for CCGs and LAs to work together to support people subject to the statutory care plan and/or intensive discharge plan.**

Recommendation 2: Ordinary Residence and Responsible Commissioner rules should be aligned cross health and social care, and should **use the current Care Act rules**, with additional rules covering people who have been placed by one area in another area, with provision for financial adjustment for some regions.

Recommendation 3: Provision of **advocacy** should be extended to those on an **Intensive Discharge Support Plan and/or entitled to s.117 aftercare.**

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Recommendation 4: Work is needed to improve how mental health and local authority services work with **housing providers to protect those who are detained from losing their property** and to ensure that provision of housing benefit and access to housing is equitable.

Recommendation 5: The **NHS** should have a clearer role in the **implementation of the Care Act**. Govt should consider if this needs an amendment to law or can be achieved via guidance and training.

We recommend a statutory responsibility for CCGs and LAs and Housing to work together to support people subject to the Statutory Care Plan or Intensive Discharge Support Plan.

We recommend that Ordinary Residence rules are aligned across health and social care so they have the same responsibility for service users and to co-operate across boundaries and decisions about responsibility are simplified. We recommend that the current Care Act rules are followed so that local areas are responsible for people in their area - but with a recommendation for people who have been placed by one area in another area and with provision for financial adjustment for those areas with a large intake of vulnerable people.

We recommend that Continuing Healthcare should be accessible for individuals to be considered for a CHC assessment. It is important to make a distinction between assessed needs related to the person's mental health disorder that can be delivered under s.117 arrangements, and those needs that to be met under a different arrangement. So, clarity is required in each case whether the individual's needs (or in some cases which elements of the individual's needs) are being funded under s.117, NHS Continuing Healthcare or any other powers. Parity of esteem can only be achieved if a person has equal access to mental and physical health care and social care. This should not be affected by the fact that someone has been detained. We therefore recommend that the current rules around the interaction between CHC and s.117 should be strengthened, so that individuals with a primary health need eligible for CHC on admission are reviewed prior to discharge. Post discharge, someone's care needs under CHC should then be reviewed to ensure that any changes are met. This should be captured in the updated statutory care plan.

Having been detained should not exclude someone from on-going CHC where their needs do not arise from, or are not related to, their mental health disorder. The hierarchy should be that pre-existing CHC responsibility, or Care Act rights, should raise a presumption that following a review the status continues, unless the mental health needs on discharge have completely superseded the prior need for the package.

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There already exists a right to advocacy under the Care Act and MHA. This has not led to a major increase in advocates being used to support care planning. We therefore suggest that the advocacy group should consider a right to advocacy for everyone subject to an Intensive Discharge Support Plan and to support the development of the plan prior to discharge.

The group felt very strongly that we should be recommending changes to the way that mental health and local authority services work with housing providers so that people do not lose their accommodation while detained and that vulnerable mentally unwell people are seen as a priority for housing.

The group feels that we should recommend to the government that they consider amending the Care Act to make NHS Trusts responsible for aspects of it alongside LAs. Alternatively, the group felt that the NHS should work with LAs to support them to implement the Care Act and so reduce the number of authorities reducing their integrated working.

The statutory care plan will capture access rights under the Care Act, Personal Health Budgets and CHC, linking in to the aims of the green paper and long-term plan. NHSE may be concerned about the performance monitoring and service provision aspects of this recommendation but we feel that this is just implementing what is already in existence and will encourage joint working across all agencies.

The statutory Care Plan will also link to, or prompt, the proposed statutory right to Advanced Decisions Making Documents and Crisis Plans. This will provide a further way in which to promote the availability of these documents and to develop good practice.

3. Rationale

Care planning and discharge planning

As identified by the CQC, the provision and quality of care planning is patchy, however, where it is delivered well, is co-produced with the service user and in a collaborative process across health and social care it can be extremely beneficial, reduce MH crisis and aid recovery. Currently care planning is only in guidance and often does not include key issues and statutory rights across agencies. This can lead to a huge variation in access to services, levels of integration and quality of care across the country and this is a major issue for service users and professionals. By making care planning a statutory requirement, with a suitable monitoring, enforcement and performance process around it, this will change the culture around care planning and ensure they are delivered consistently and to a high quality. The group believes this can be justified on the ground of the benefits to society of someone getting the care and support they need. We also

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believe that improved care planning is a key part of developing services based on prevention and recovery and will lead to reduced admission in future and improved outcomes for service users and their families.

The Intensive Discharge Support Plan, for all patients leaving an inpatient setting, will provide additional support, as we believe there is a case for additional support to be provided for those leaving hospital, in recognition of how disruptive detention can be, especially if for a long period.

Someone's needs immediately after discharge may be different to their on-going need and therefore there needs to be a process to assess and meet these, and end them when no longer required. However, we are clear that, for those entitled to s.117, aftercare provision goes beyond this and is not limited to meeting needs arising from disruption during the discharge period but instead aimed at preventing deterioration and readmission.

By formalising the process, setting a quality expectation for the process and regulating/enforcing this, we hope it should tackle the concerns heard from service users and patients. We would also hope that good discharge planning can help reduce readmission.

A personalised plan, with specific provision commissioned if not available, will also ensure a person-centred approach rather than simply being discharged to pre-existing community services. Having a robust plan in place, in a single document with multiple sections, which is shared with the patient will help tackle the confusion reported by service users, carers and professionals, support consistency of care and mean that people can be transferred between agencies and primary secondary – as recommended in the community MH review.

Nobody would be discharged from an inpatient or institutional setting without these duties being met. There is a risk that this could slow down discharge and block beds, however if done properly and planning for discharge starts as soon as someone is admitted experience shows that this improves patient flow and frees up bed space. This also reduces the concern that people are being discharged inappropriately.

In regard to the Statutory Care Plan, whilst the new legal requirement would be a gateway to existing rights (including s.117 when eligible), the group believes making this a new statutory requirement, rather than the current position of this being in guidance, will help drive a culture change amongst NHS and LAs, as the care plan and its contents are actually legally enforceable.

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Further work is required to determine:

- Whether any additional qualifiers are needed, beyond contact with secondary MH services, to trigger eligibility for the statutory care plan.
- Who would enforce/ monitor the implementation of both plans?
- What the implications would be for the CCG and the LA if this was not met.
- How service users could raise concerns with the quality of their care plan and/ or discharge plan. This should also consider the possibilities for service users to delay their own discharge if they did not feel they had the right plan in place.

Funding

There is current inequality in s.117. Its implementation is patchy, which means that while some service users have access to free health and social care for as long as they need it, other service users have to fight to get the rights they should be getting.

The fairest way to address this would be to make all services for vulnerable people with a mental health problem and eligible for care and support under the Care Act free. However, we recognise that this could require significant additional funding, and could raise issues of equality for those with long-term care needs not related to mental health.

However, we do believe there is a case for free provision of services, which would otherwise be charged for, to provide additional support after discharge. For those on shorter sections this should be for a limited period. For those detained under s.117 eligible provisions, this lasts until 'the person concerned is no longer in need of such services'.

Introducing time periods which set an expectation for the duration of post-hospital care dependent on the nature or duration of someone's detention/ time in hospital aims to ensure that everyone has access to a good discharge process and intensive support in this initial, and high risk, period when discharged. This aims to help tackle the current inequality of some patients leaving a period of detention hospital without any non-means tested social care support, whilst others get long-term social care and additional services free at point of access.

We have heard of issues around the current provision of services where service users have care needs which span health and social care, and at the most extreme of court cases to determine who pays for what. In order to ensure care planning (both the statutory care plan and the intensive discharge support plan) is person centred and focused on what an individual needs, rather than who pays, we recommend a radical simplification of the funding.

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We have recommended a possible single 50:50 funding pot. Further options for consideration include:

- That the Govt should allocate to each regional STP or ICS a joint fund from which to pay for these services locally based on the level of need.
- That each STP or ICS partnership should consider the integrated commissioning of local services that will reduce the number of people in expensive out of area placements.
- That the long-term care needs of adults of a working age should be paid for from central govt taxation and free at the point of need.
- The CCG and LA should pay into a single commissioning entirety pot (some local areas have already agreed to do this and found a simple 50:50 split is effective)

Central funding would address the burden on certain trusts and LAs which have higher inpatient beds or specialist care units and therefore more people discharged into their areas.

Content of care plans and Intensive Discharge and Support Plan

Experience shows that if care planning is not defined then it will be developed by case law. However, the group were concerned that writing a definitive list of what should and shouldn't be included in care planning and discharge planning risked the process not being person-centred and potentially replicating the poor practice in CPA of planning becoming a tick box exercise.

Instead, therefore, there should be statements about what the plans are for and clear guidance on how they interact with existing duties and provision.

Further work should be done to safeguard access to, or maintaining, stable accommodation when people are Mental Health inpatients, whether voluntary or detained. One potential option could be to exempt housing from the Intensive Discharge Support Plan where a duty is owed under housing legislation. This would mean that if someone was facing a discharge to homelessness the discharge arrangements would have to involve housing authorities to assess entitlement to homelessness assistance. A further improvement would be to address the disparity between physical and mental health when assessing priority of need for housing.

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Organisation/infrastructure issues

In relation to Ordinary Residence (OR) and Responsible Commissioner Guidance, the ToR asked us to: 'resolve some of the complex arrangements across Health and Social Care especially in relation to 'ordinary residence'. We have set out to simplify the OR rules so that they follow clear and sensible structures and reduce administration burden and complex arrangements where CCGs and LAs are funding people in a range of different ways.

Responsible commissioner rules for provision for decisions around ordinary residence and care so that both LAs and CCGs have the same responsibility under the Care Act – but with a specific recommendation in relation to people who have been placed by one area in another area and a more robust responsibility to cooperate across agencies and boundaries

4. Implementation of recommendations

Implementation of these recommendations will require a multi-agency and cross-government commitment. Legislative changes are required and there are implications for funding and the upcoming spending review.

This topic is complicated by the number of wider reforms and agendas which this interacts with, however, we are confident that the recommendations above are in the spirit of these wider reforms, and could be taken forward through these processes.

There will be cost implications for the extension services under the Intensive Discharge Support Plan to all people being discharged from hospital and free of charge for all those who have been detained. We have not been able to get accurate information on the average cost of s117 in every area – although there is clearly unwarranted variation. However, this will be mitigated through:

- A clearer framework for reviewing needs and support
- Reduced numbers of inpatients – through changes in MCA, increasing alternatives to detention and better community services

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Asian and minority ethnicities

Chair: Raf Hamaiza, Expert by Experience Lead, Cygnet Health Care

Working group lead: Andy Bell, Deputy Chief Executive, Centre for Mental Health

Secretariat: Graham Sale, DHSC

Membership

- Tim Gunning, Equality and Human Rights Commission
- Yasir Hameed, Norfolk and Suffolk NHS Foundation Trust and University of East Anglia
- Nusrat Husain, Lancashire Care NHS Foundation Trust and University of Manchester
- Samir Jeraj, Race Equality Foundation
- Sabrina Kamayah, Care Quality Commission
- Claire Lesko, Equality and Human Rights Commission
- Anthony Salla, University of Nottingham
- Simon Torkington, Mary Seacole House

In addition to the core members, the group may bring in expert contributors for specific issues within the topic, or to test emerging findings.

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Terms of reference

Remit

The role of this group is to seek to understand more about the experiences of Asian and minority ethnic communities (eg Arab) and ways in which the Act could work better for a diverse range of people and communities. The interim report said the review will consider further:

- The experiences of Asian and minority ethnic people of being detained and treated under the Mental Health Act, including interactions with primary care, social care and criminal justice systems.
- Why people from Asian and minority ethnic communities are more likely to be given Community Treatment Orders (CTOs) and with what outcomes.
- Why some Asian and minority ethnic groups have worse outcomes, including but not limited to being more likely to relapse when they left hospital.
- Whether specific changes to the Mental Health Act 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 Asian and minority ethnic communities.

The topic group will consider how current inequalities can be addressed in relation to the Mental Health Act, and any recommendations will consider the potential impact upon individuals identifying with protected characteristics under the Equality Act 2010. In particular, the review is seeking to address racial disparities, with a specific emphasis on people of African and Caribbean descent or heritage.

The purpose of this group is to identify potential recommendations the review could make, in relation to the above and to support the review's overarching goals (see below).

The group will review existing data and research (qualitative and/or quantitative), including responses to the review's service user and carer survey and submissions to the call for evidence, about Asian and minority ethnic experiences, commissioning additional work to address gaps as necessary.

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Up to three consultation events will be hosted with community organisations across the country to develop a deeper understanding of how the Act is experienced and whether there are examples of initiatives or approaches that might help to reduce inequalities. Discussion will focus on people's experiences of the Act and include a range of prompts around issues of particular concern (eg section 136, restrictive practices, CTOs, advocacy).

Timing and outputs

The group will meet formally three times in addition to a range of engagement events.

i. Review point

Additional research requirements will have been identified and commissioned ahead of the midpoint (31 July 2018), with dedicated engagement events underway to seek direct input from individuals of different ethnic groups.

A progress update will be submitted to the review by 20 July 2018.

ii. Final report

The group will produce specific recommendations with regard to Asian and minority ethnic communities, strengthening the existing evidence base and narrative to underpin any suggested interventions.

The group will to produce a short report to the review leadership by 14 September 2018, using the agreed format, setting out key findings for consideration by the Review as they prepare their final report and recommendations to government.

The group's work will be supplemented by additional engagement activity.

Interdependencies

This group needs to work particularly closely with the African and Caribbean group to align thinking and share intelligence.

It is also important to liaise with the other topic groups (such as Advocacy and Community Treatment Orders) to ensure that a wider race equality dimension is included in their thinking and that proposals are tested in both directions.

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Goals set out in the review's interim report

- 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

Report

1. Issue

To date the review has focussed solely on the disparities identified in relation to detention under the Mental Health Act by African and Caribbean communities. The role of the Asian and minority ethnicities (AME) group was to seek to understand more about the experiences of Asian and other ethnic minority communities (eg Arab) and ways in which the Act could work better for a diverse range of people.

Historically, there is a lack of good quality data from national surveys on the prevalence of mental ill health among members of black, Asian and minority ethnic (BAME) communities. Sample sizes of BAME community members involved in national mental health prevalence surveys are historically low, making findings unreliable. Further, certain problems of aggregation in relation to national figures (such as the broad ethnic categories reported through the Mental Health Services Data Set (MHSDS), for example) can lead to often misleading conclusions.

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With these caveats in mind, it has been concluded that Asian adults are the second least likely group to be receiving treatment for mental or emotional problems⁵⁸. NHS Digital data shows rates of contact and detention per 100,000 population are low for the Asian group; however, a high proportion of those in the Asian group admitted to hospital are detained under the Act⁵⁹. This suggests access to secondary mental health and learning disability services might be a concern for this group – Asian people may not be seeking the help they need (ie low rates of contact) and their mental health deteriorates to the point where they are detained under the Act, thus resulting in a high proportion of detainees out of hospital admissions.

More generally, some further findings provide helpful context:

- Among white people, Irish people (69.5 per 100,000) are slightly more often detained than white British (64.3), while those of 'other' white communities (132.8) are twice as likely to be detained.
- Among Asian people, those of Indian ethnicity (53.2) are less likely than average to be detained, while Pakistani people (97.4) have higher rates and Bangladeshi people (109.3) higher still.
- The least likely ethnic group to be detained is Chinese (47.8) while those categorised as coming from 'any other ethnic group' have a far higher rate of detention (436.2).
- High rates for CTOs are also found among Pakistani (15.1) and Bangladeshi (17.4) communities.

Limited understanding of the routes to, and experience of, detention is compounded by a general lack of evidence on the outcomes people from BAME communities experience from mental health services and after being detained.

The challenge for the group was therefore to consider (limited) existing formal evidence on AME communities, complemented by anecdotal evidence and professional experience, and to propose recommendations for improvement – both in understanding and, consequently, patient experience.

⁵⁸ Adult Psychiatric Morbidity Survey (APMS),

⁵⁹ Mental Health Services Data Set (MHSDS)

2. Findings

We propose five specific actions to address the experiences of people from Asian and minority ethnic communities of the Mental Health Act.

1. Require organisations involved in the MHA to **record and review ethnicity** at every stage, using an agreed (with EHRC) set of definitions to ensure we have better data about treatment of full range of ethnic communities (including those smaller in number & people of mixed heritage). This should be consistent between the NHS and local authorities and should extend to the criminal justice system to cover police, courts and prisons (eg sections 136, 37/41). Data should make it possible to compare ethnicity by gender and age (and other demographics) and record actions, incidents and outcomes (eg the use of seclusion or restraint) to build a fuller picture of people's experiences of the Act.

2. Create safeguards for people to continue **religious or spiritual practices** while detained in hospital and to prevent the use of restrictive practices that limit a person's access to religious observance. This may include a positive duty on service providers to make facilities available and should ensure that people are enabled to participate (eg by facilitating access to a minister, not simply making a room available for worship). It should extend to areas with lower BAME populations where this may be more challenging. Where a clinical decision is made to restrict a person's access, for example because of safety concerns, we believe this should be recorded, with clear reasons given by the clinician about why this happened.

3. Ensure fair and equitable treatment in the **criminal justice system** and under Part 3 of the MHA. We are making two recommendations under this heading:

3a. First, to speed up **hospital transfers** for people in prison from AME backgrounds. This should include ensuring that if people are moved between prisons while awaiting a transfer it does not delay proceedings.

3b. Second, we recommend specific action to protect against **bias in decision-making** (eg about moving between levels of security, discharges from hospital or the ending of restriction orders for people who have been discharged from inpatient care). We are concerned that a person's name or appearance might have a negative influence on decision-making and would like to see safeguards developed to address this.

Data about ethnicity should be published routinely in order to identify any disparities in the CJS and Part 3.

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4. An extended statutory right to **advocacy** throughout the system that is culturally and ethnically relevant and that is proactive in supporting people to assert their rights and wishes. This should include enhancing the provision of Independent Mental Health Act (IMHA) services and the training of advocates to work effectively with people from diverse AME backgrounds, and supporting the development of other advocacy services that go beyond the role of IMHA. The group recommended that continuity of support from an advocate when a person leaves hospital would be helpful, particularly for people who move onto a CTO, and for those who have been in hospital outside their local area and in independent sector beds. It is particularly important that culturally-appropriate advocacy is available in areas with lower levels of diversity where existing community-led services may not be so accessible to people who are subject to the Act. We would also recommend the development of a robust training curriculum for IMHAs, and arrangements to ensure that practitioners are fit to practise and that concerns about quality area addressed appropriately.

5. There is an urgent need for **research** to address the needs and experiences of people from a wider range of AME communities who are subject to the Mental Health Act. We are concerned that the review had very little high-quality research to work with in understanding people's experiences of being detained or being on a CTO. It is vital that research funding is directed towards studies that will provide greater intelligence about these experiences, working with communities in partnership, in order to inform further service development and policy change.

In addition to these proposals, we strongly endorse the recommendations of the Mental Health Act Review **African and Caribbean group (MHARAC)** and see significant benefits of their approach for a wider range of communities, especially those that experience the biggest inequalities and highest levels of discrimination.

3. Rationale

1. Record and review ethnicity

The limitations of current national data reporting on Mental Health (by NHS Digital) fundamentally hampers our understanding of experiences and disparities experienced by certain groups. For example, the 'any other mixed background' category is a catch all and unable to be broken down further.

Moreover, a fundamental lack of ethnicity data in other public bodies limits the ability to understand the experience of certain ethnic groups. For example, a disparity in experience and outcome between individuals convicted for the same offence (eg sections 47/49 versus s135/136) may suggest that there is a systematic issue with court decision making.

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The group expressed concern surrounding the use of ethnicity as the primary categorisation within data collections as many people identify with two or more ethnicities. Fundamentally, the need to understand (and identify) a person's identity is central to providing an effective service – for example, the high levels of trauma often experienced by migrants as opposed to those who are British-born, but whom, within data collections, may currently be identified as comparable individuals. There was recognition of the potential burden of overcomplicating data collection by specifying too many discrete categories, yet this should not act as a barrier to collation of appropriate information – for example, there should be an option for individuals to specify type of 'other' in free text, which would result in the need for additional analytical interpretation but ultimately mitigate the risk of skewed data collection.

It should be noted that the AME group is supportive of the MHARAC group's proposal to develop and implement an Organisational Competence Framework, an aim of which is to improve the systematic collection of data across public bodies eg trusts, courts and tribunals. The group particularly endorses the need for adequate leadership to drive change across organisations, such as through appropriate representation on trust boards.

2. Religious or spiritual practices

A fundamental lack of understanding, or even a basic appreciation of different religious/cultural beliefs, can impact upon the experience of detention under the Mental Health Act for different ethnic groups. This is a shared area of concern with the Patient Dignity and Safety group, and links into wider concerns surrounding patient autonomy.

Data from the Care Quality Commission (CQC) intelligence network highlights that 75% of BAME patients are distributed in approximately 50% of hospitals. Some of the worst instance, for example where BAME patient deaths have occurred, take place in areas with limited numbers of BAME patients using the service at any one time.

Anecdotal evidence supports the fact that out of area placements are particularly detrimental to experience of religious/spiritual restriction, which are more common in the independent sector. The group raised the possibility of religious needs being included as part of the essential decision-making criteria for placements, but ruled out this option due primarily to logistical issues (eg safety concerns and bed availability). More fundamentally, however, the principle that only certain areas/hospitals are able to cater for the diverse needs of ethnic minority communities is concerning, and should not be encouraged. Finally, the policy intent to eradicate Out of Area Placements (OAPs) altogether should not be undermined by secondary criteria to limit their use.

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The potential for a hospital to be made aware of an individual's religious needs prior to admission should be considered as part of advance choice documentation, pending changes to expand the current model beyond the focus on treatment decisions to include wider preferences. Nevertheless, services should be flexible enough to have the ability to respond to an individual's religious needs, and should not necessarily need to know about this in advance – the right questions should be asked upon admission (pending any concerns resulting from a capacity assessment), with the support of an advocate if necessary. Despite religious need currently forming a part of the referral/admission process, anecdotal evidence points to the fact that this is frequently marked as 'no significant need' with little justification.

Within a service there should be no grounds to prevent individuals from attending a multi-faith room. A basic problem exists surrounding access to multi-faith rooms rather than provision across hospital sites, with the majority of Trusts complying fully. In future, therefore, Trusts should be expected to monitor access to multi-faith rooms and any decisions surrounding restriction recorded centrally. This could also involve the IMHA (or other statutory or non-statutory advocate) involved in a person's care, and links with the Advocacy group's recommendation about a bolstered role for IMHAs in relation to quality assurance of service provision.

Whilst mindful of the precedence of practical matters (such as safety concerns and availability of beds), the proposal is for a tiered model of religious provision responding to availability of religious facilities and/or spiritual leaders in the area. This could range from accompanied visits to religious buildings within the vicinity of the hospital to facilitated access to religious counsel via telephone, if appropriate. In doing so, the approach we are encouraging is proportionate and respects multiple other pressures on wider service provision.

Further, it was suggested that renewed funding for the Equality Advisory Support Service (run by the Equality and Human Rights Commission (EHRC)), or similar, may be warranted to offer external advice/support facility to patients and/or staff in fulfilling duties under the Equality Act. This suggestion was not developed in detail.

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3. Criminal justice system

3a. Hospital transfers

We are aware that the Criminal Justice System and 'Part 3' of the Act topic group is exploring this issue in depth and will be producing its own findings and recommendations for the Review. The AME topic group hopes that these recommendations will lead to a significant reduction in the time taken to bring about a hospital transfer from prison. It will be vital that decision-making is recorded by ethnicity to ensure that people from AME backgrounds are not disadvantaged at any point in the pathway.

The group considered a possible recommendation that the start of process to transfer to hospital (eg gateway, assessment) precludes internal moves within the prison system. This was concluded to be an unworkable option because of the potential conflict with the role of a Governor to manage a prison safely, and risked significant pushback from the Ministry of Justice (MoJ) and other interested parties on these grounds.

3b. Bias in decision-making

Evidence from a range of other areas suggests that bias (conscious or unconscious) affects decision-making: that a person's name or physical appearance can have an impact on how a decision-maker interprets information. We believe that safeguards are necessary to reduce the risk of a person's ethnicity or religion affecting a decision made about them under Part 3 of the MHA. For example, where the MoJ is making decisions on paper about a person's continued detention or the continuation of a restriction order, anonymising the individual would reduce the risk of subjective bias in this process.

4. Advocacy

The AME group is largely in support of the Advocacy group's emerging recommendations surrounding access to and eligibility for IMHAs under the Mental Health Act. A role for advocates throughout the care pathway, including continuity beyond discharge, is key to preventing admission, and links with the Advocacy group's recommendations on widened eligibility. The group also supported the need for greater cultural awareness amongst the existing IMHA workforce to respond to the needs of diverse ethnic communities.

However, in line with the MHARAC group's recommendations, a need for specific culturally-appropriate advocacy services over and above IMHA provision – at appropriate points throughout the pathway – was strongly supported.

The professionalisation of statutory IMHA provision has removed it from the community-based non-statutory models which have greater freedom, flexibility and creativity to respond to the needs of certain minority groups on a case-by-case basis. There is a clear

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need for both in a system to ensure an adequate standard of provision for all (in this case the detained population) whilst allowing sufficient flexibility to respond to the particular needs of the individual.

The AME group's preference is for organisations based in the community who are representative of the area they work in. Services that support people to live independently in the community and provide training in daily living skills will, inevitably, have a role in improving mental wellbeing and reducing the need for detention at points of crisis. However, the needs of smaller AME communities, or those living away from community organisations, should also not be overlooked.

In addition, people with experience of the services and systems they are supporting people within should include experts by experience, with training to understand mental health and the system, commitment to challenge the system and a professional approach to every aspect of what they do. Examples of co-produced peer-led advocacy training programmes (such as a pilot in forensic care in Birmingham) offer a model which may be considered for further roll out, as well as Peer Advocacy Training Programmes run by organisations such as Mary Seacole House in Liverpool.

5. Research

The call for further research on interventions for black African and Caribbean people should be mirrored in relation to AME group. This is particularly important considering the fact that, whilst general awareness of the experiences of black African and Caribbean people is present in an existing body of research (albeit flawed as per the MHARAC group's report), this is not the case for AME groups. There is therefore a clear need to build understanding of experience and potential interventions for other ethnic minority groups.

We believe that investment is required in research that seeks to understand the experiences of a wide range of AME communities of mental health services in general and the Act in particular. Research should include co-produced studies that work alongside communities to understand people's experiences and highlight the narratives and views of those who have lived through it.

4. Implementation of recommendations

1. Record and review ethnicity

With reference to existing legislation, including but not limited to the Equality Act, public sector organisations (under the Public Sector Equality Duty) have a duty to consider the advancement of equalities as a central part of the design of policies and the delivery of services. Robust data collection is key to understanding racial disparities in service provision, yet a lack of available data to interrogate limits the ability to respond objectively. This stems primarily from the point at which data is collected, meaning that existing methods are insufficient in collecting the necessary granularity of detail.

First and foremost, therefore, ethnicity markers should be incorporated into routine datasets and services should be expected to comply. The approach across organisations should be standardised against a common set of definitions (agreed in consultation with the EHRC) to allow cross-fertilisation and analysis of multiple datasets. An agreed approach will need to be directed by government, possibly as part of the ongoing Race Disparity Audit, and may helpfully be extended to incorporate additional protected characteristics under the Equality Act. Transparency of all resultant data for public scrutiny, as well as academic research purposes, is paramount to ensure greater collective understanding and appreciation of trends (and possible policy interventions). Regular monitoring will need to be undertaken by key arm's-length bodies (ALBs) including NHS Digital and the CQC to assess participation levels and quality, with private providers of NHS services also expected to participate.

In relation to the Mental Health Act specifically, guidance underpinning the existing legislation (such as the Code of Practice) may be updated to clearly state the duty on all public organisations to ensure data sources are able to be disaggregated by ethnicity.

2. Religious or spiritual practices

Again, existing duties under the Equality Act outline the need for public bodies not to discriminate against individuals on the basis of religion or belief. As such, greater efforts need to be made in terms of directing services to cater for the needs of individuals within their care.

When commissioning services, commissioners should look to ensure adherence to religious need through contracting processes; similarly, guidance should be issued to commissioners and providers outlining steps to be taken to ensure the removal of restrictive practices, including expectations for monitoring and recording of decision making processes. Oversight of performance should be monitored regularly by the CQC (potentially as a prerequisite for 'excellent' under the 'well led and responsive' criteria of inspection reporting), and services failing to respond should be sanctioned appropriately.

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Further, patients and families/carers should have a legitimate route to raise concerns (possibly with the support of an advocate) both within the trust and externally.

Training of staff, and advocates, may be necessary to ensure recognition of the cultural needs of individuals and how to respond appropriately. The route to tailored individual-level decision making need not have explicit financial implications, however, as the anticipated service response should cater for need whilst being proportionate in relation to provision in the region.

Finally, the mechanism whereby religious or spiritual need is communicated to staff by patients may include via an advance choice document, which is particularly important in cases where the patient has been assessed and deemed to lack capacity. It is therefore important to ensure that information is held in a way that protects confidentiality while being accessible to those who need it, with the potential for a centralised system to be used for advanced decision-making documents. NHS and local government bodies will necessarily have a role in establishing the parameters and mechanism to enable sharing of confidential information across a centralised system.

3. Criminal justice system

3a. Hospital transfers

NHS England is currently working on guidance to improve hospital transfer process from prisons, in collaboration with the MoJ. This should make clear that the hospital transfer assessment process should not start again if a patient is transferred within the prison system.

3b. Bias in decision-making

The group is aware of wider recommendations made through the Criminal Justice System and 'Part 3' of the Act group to change the role of the MoJ and/or Her Majesty's Prison and Probation Service (HMPPS) in relation to decision-making for restricted patients. Any potential changes to the decision-making body, however, would not remove the possibility of bias in the decision-making process. Clear guidance governing the parameters of the decision-making process, outlining actors and levels of disclosure within the system, will therefore be necessary to ensure a robust process. Conversations with MoJ and/or HMPPS would be a necessary first step, taking account of current decision-making processes and identifying opportunities for change. The potential for oversight will also need to be considered, necessarily in collaboration with MoJ and Department of Health (DH) ALBs.

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4. Advocacy

Further pilots will need to be undertaken, based on the outputs and feedback from current pilots such as the Birmingham secure care programme. The commissioning of specific advocates to cater for the needs of particular individuals, over and above current IMHA provision, is likely to have significant additional resourcing and financial implications – these costs will be borne by local authorities, and will therefore need to be adequately reflected in government budget-setting processes. However, the potential for reduced length of stay, and less revolving door experiences, could outweigh any upfront development.

5. Research

This would require engagement with Research Councils, the National Institute for Health Research (NIHR) and other major funders to encourage them to direct funding towards research that would address the gaps in the evidence base and inform future policy and practice.

5. Evidence and analysis

Focus groups

The general lack of interpretable data and research surrounding many ethnic minority communities was a key challenge for the AME group.

As such, the group worked with organisations such as the Race Equality Foundation to arrange focus groups targeting specific communities with which the Review struggled to engage in its first phase. The outputs from these focus groups should be considered during the next phase of the review's work.

Survey responses

The Review's service user and carer survey received limited responses from BAME individuals, but did stress the need for culturally-responsive services.

The need for greater cultural awareness training amongst mental health professionals was also raised by a very small number of respondents. Those mentioning it did not describe what this might look like. One respondent suggested that people from BAME communities should have a right to culturally responsive services:

“...the right to services responsive to BAME communities if requested as part of the aftercare plan...” (CAR1458)

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Call for evidence

The Review's call for evidence included a large number of responses in relation to the overrepresentation of certain BAME communities in detention. These largely focused on black African and Caribbean populations, and few proposals put forward specific solutions for identified issues, but nevertheless offer a helpful context for the findings from the AME group's work.

A service-level evaluation from a trust in North-West England focusing on the mental health needs of the large asylum seeker population found that collaboration and cooperation between health and other agencies (eg housing, employment, education) were key. It also flagged the need for staff to appreciate multiple disadvantages, understand relevant legislation and know about entitlements (including access to advocates and interpreters) as necessary.

Academic research on culturally-appropriate advocacy (albeit focussed on the needs of black African and Caribbean men) raised concerns surrounding the lack of sustainable funding for services developed by the community and voluntary sector acting as a barrier to the development of effective, high-quality advocacy for a particular ethnic group⁶⁰.

Councils were specifically recognised as playing a central role in more cost-effective, early intervention and mental wellness initiatives in order to prevent later treatment of serious mental health issues at the point of crisis. Focused education 'insight' events were suggested to improve BAME engagement with mental health services. Further, alternative provision at the point of crisis, including crisis cafes which reflect local BAME demographics, were also suggested as real alternatives to admission.

⁶⁰ Newbigging, K., McKeown, M., & French, B. (2013). Mental health advocacy and African and Caribbean men: Good practice principles and organizational models for delivery. *Health Expectations*, 16(1), 80-104.

Annex 1: Comments on wider recommendations

In addition to the recommendations above surrounding data availability (in relation to the OCF) and research from the MHARAC group, the group also commented on wider emerging recommendations from across the review:

Family and carer involvement group

- The AME group support the idea of a low threshold for capacity in relation to nominating a family member, and support the 'two attempts' fall back mechanism for nomination when an individual lacks capacity.
 - Particular examples could include provision of translation services and support for travel costs. The service itself should resource these.
 - Personalisation is a theme which should be promoted (eg choosing a meal), particularly in relation to those people without English as their first language.
- The mental health needs of carers themselves should also be considered – including the ability to get back into employment.
- S.17 leave is sometimes only granted if family members/parents are available to escort the individual.
 - Building relationships between staff and families, including proactively reaching out to get them involved in care, is beneficial to promote involvement in recovery.
- The role of 'cultural brokers' in New Zealand is critical in providing cultural intelligence, helping to build links with community routes (eg voluntary sector).
 - Certain similarities to Equality and Diversity Champions – a scheme piloted in Cygnet Healthcare and open to all members of staff. Critically this promotes cultural awareness as 'everyone's business' rather than one person's role in isolation.
 - MH First Aid model in Australia promotes children training each other.
- Nearest relatives typically do not understand role/know rights – and the system needs to help them understand.

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Police

- Police involvement in relation to immigration is important.
 - Many people held at airports experience mental distress, which is undiagnosed and not catered for adequately in deportation/immigration centres.
 - Some individuals are taken to places of safety, whereas others (most) are taken to prison. A decision is taken by the person in charge – and may be subject to bias.
 - We would encourage an understanding with Home Office that the NHS raises an alert when people do not carry the correct documentation.
 - Also, the position in primary care is clearer than in secondary – but there is still some confusion about what people are eligible for (ie not chargeable for care when detained, but are for anything voluntary).
- Bias is again relevant when people with mental disorders are perceived as under the influence of alcohol or drugs.

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Children and young people

Chair: Mark Hedley

Working Group Leads: Kim Forrester and Pauline Carpenter

Secretariat: Katy Lindfield, DHSC

Membership

- Dr Cornelius Ani, Psychiatrist
- Camilla Parker, Solicitor
- Janet Blair, Social worker/AMHP
- Marc Bush, YoungMinds
- Michelle Long, Carer

In addition to the core members, the topic group may bring in expert contributors for specific issues within the topic, or to test emerging findings.

Terms of reference

Remit

The interim report said the review 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

The group will consider how current inequalities can be addressed in relation to the Mental Health Act, and any recommendations will consider the potential impact upon individuals identifying with protected characteristics under the Equality Act 2010. In particular, the review is seeking to address racial disparities, with a specific emphasis on people of African and Caribbean descent or heritage.

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The purpose of this group is to identify potential recommendations the review could make, in relation to the above and to support the review's overarching goals (see below).

This group will not be duplicating work outlined in or as a result of Future in Mind and The Five Year Forward View for Mental Health.

It will be important to examine the issues in the wider context and the overall system for children and young people. The review may be able to identify issues that impact the wider system and highlight these to government but detailed recommendations will be limited to the Mental Health Act setting.

A key task of this group will be to explore the considering submissions to the call for evidence, current work programmes led by the NHS and CQC as well as examining the legislative frameworks and associated guidance in order to understand what barriers exist to deliver care and treatment. This will include how these tools are used and how effective they are when implemented.

There will be specific areas of focus on:

- The transfer issues between child and adult services
- Out of area placement processes for CYP, consent and competence
- Identifying the impacts of CYP definition varying in law and practice eg planned developments for CYP services and extension from age 18 to age 25 cap or statutory context for children with special educational needs (also 25).

Timing and outputs

The topic group will produce a short report, using the outputs template.

There will be two, half day meetings between June and August. There will also be a desktop exercise to cross-check all other recommendations for the CYP agenda and to return comments to the Chair.

i. Review point:

Gap analysis and any additional research requirements by May 2018.

Progress update to the review by 31st July 2018.

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ii. Final report

The group will produce a short report to the review leadership by 14th September 2018, using the agreed format, setting out key findings for consideration by the Review as they prepare their final report and recommendations to government.

The topic group's work will be supplemented by additional engagement activity.

Interdependencies

The CYP topic group will need to specifically consider other reforms being proposed to the MHA to ensure that suitable modifications apply in relation to those under 18. This will be particularly relevant to:

- Patient autonomy
- Family/carer involvement
- Discharge and aftercare
- Mental Capacity Act interface
- Procedural safeguards
- Tribunals
- Discharge and aftercare

Goals set out in the review's interim report

- 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

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

Report

1. Issue

The Interim Report of the Independent Mental Health Act (MHA) Review identified a number of issues that are specific to Children and Young People (CYP) in relation to detention under the Mental Health Act including:

- specific legal issues which arise in relation to the assessment and treatment of young people in particular because they may well be subject to different legal frameworks;
- legal complexities and ambiguities surrounding admission and consent including the role of parental responsibility;
- concerns about information-sharing and the need for CYP and their carers to be given clear and comprehensive information about processes and care and treatment under the MHA;
- issues with CYP being treated in appropriate settings close to home

In addition, the group considered the:

- comparatively higher proportion of CYP subject to informal detention and the lack of safeguards around their care and treatment.

2. Findings

A. Key areas and recommendations

1. Safeguards following informal admission.

Data from 2016 suggests that a much higher proportion of CYP are admitted as informal patients compared with the general adult patient population. No doubt the influence (and sometimes authority) of those with parental responsibility are a significant explanation. A person admitted informally has inevitably no right to the Tribunal service or other safeguards since they are legally free to leave at any time. This does not represent reality for many CYP and accordingly it is essential that there should be further safeguards. We would recommend that legislation is amended to make the following changes for CYP admitted informally:

- a right of access to IMHA, sufficiently trained in working with CYP and their families;
- a personalised care & treatment plan that places the CYP at the centre and works with them and their family/representative to identify the support that matters to them. The plan to set out the model of care and treatment(s) proposed and recording the views of the CYP in respect of each matter
- a formal review of the care plan along similar lines to the looked-after child (LAC) Review under the Children Act to include:
 - whether it continues to be appropriate to provide in-patient treatment and care on an informal basis
 - whether the CYP should continue to be treated in hospital and whether appropriate discharge planning is in place
 - the appropriateness of the placement and the physical conditions in which the CYP is accommodated (eg whether another hospital would be better)
 - a review of the care and treatment (including non-medical therapeutic approaches) being provided to the CYP.
 - input from all those involved in the admission and care and treatment (including all therapeutic approaches being taken) of the CYP
 - transition planning ensuring that community education and social services are aware of the transition so joint planning focussed on the needs of the CYP can take place as appropriate.

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- the first of the reviews to take place within 5 days of emergency admission (in line with NHS England's service specification for Tier 4 Child and Adolescent Mental Health Services⁶¹) and thereafter at 4 weekly intervals while the CYP continues to be treated in a hospital;
- for second opinion appointed doctors (SOADs) to be part of the first 4 weekly review (considering all aspects of the care and treatment plan) and included in later reviews as considered appropriate by the Chair
- reviews should take a child-centred approach and involve parents and carers except where there are specific objections to doing so (eg where there is a known safeguarding risk relating to the parent or carer)
- that to support the above recommendation amendments are made to the MHA Code of Practice in order to enhance guidance on sharing information with those with Parental Responsibility (PR) (ie how best to provide sufficient information to those with PR to provide care and support post discharge or during treatment, and in navigating conflicts between the wishes/needs of those with PR and CYP)
- each review should have an independent chair who has knowledge of the CYP legal framework, sufficient authority to chair meetings and an understanding of the particular issues affecting CYP.

During this discussion the limitations on the number of SOADs and its implications on the practicality of SOAD involvement in the first four weekly review was raised. However, the group considered that it was important that there was SOAD involvement in the independent reviews and it was agreed that the recommendation should be made. The group also acknowledged that other groups were looking at the SOAD role which could result in increased numbers of SOADs.

⁶¹ Child and Adolescent Mental Health Services Tier 4 (CAMHS T4): General Adolescent Services including specialist eating disorder services

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2. Ability to decide⁶² and consent

The whole question of the ability to decide and consent in CYP is unnecessarily and unhelpfully complicated at the present time. CYP aged 16 – 17 who have the ability to decide may consent to admission, and treatment irrespective of the views of those who hold parental responsibility (PR). PR may not be used to admit a young person if that young person does not consent to the admission. Although the Code of Practice says a young person who has the capacity to make such decisions and refuses treatment should not be treated on the basis of the authority of PR, there is statutory silence on this point. Similarly, the situation of those under 16 who have the ability to decide is addressed in the Code of Practice (stating that 'it would not be advisable to rely on the consent of a parent with parental responsibility to admit or treat a child who is competent to make the decision and does not consent to it') but not the MHA 1983. We favour a consistent approach to the ability to decide for all CYP. Accordingly, we would recommend:

- that the "functional" test under section 3 of the Mental Capacity Act 2005 (MCA) should be the single test for the ability to decide for CYP of any age;
- that in relation to those aged 16 and over the ability to decide should be presumed unless the contrary is established (as the MCA requires);
- in relation to those under 16 the ability to decide needs to be established (as Gillick so requires);
- that neither admission, remaining in hospital or treatment should be imposed in reliance on PR on any CYP with the ability to decide who is not consenting (the MHA should be used in these circumstances). The current exception to this, where failure to treat would lead to death or serious permanent injury, should stand (para 19.71 – 19.72 of the MHA Code of Practice);
- that Section 131 of the MHA should be amended to make that clear;
- that the current provisions in the MHA Code of Practice (revised and/or strengthened as needed in the light of case law) are retained for CYP without the ability to make decisions (currently 19.41 – 19.42 of the MHA Code of Practice). CYP who are informally admitted will be subject to the additional safeguards recommended in A.1 above.

⁶² In order to avoid confusion and ensure consistency the group has agreed to use the term 'ability to decide' to describe all CYP who have either competence or capacity

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We note that the right of CYP to object to psychiatric examination or assessment is already established in at least two provisions of the Children Act 1989 though there may be circumstances as established by case law where this right may be overridden and of course there remains the defence of necessity.

We also note that informal admission under the MCA is only possible where there is no deprivation of liberty and that the Supreme Court is due to consider the role of parental consent and deprivation of liberty.

Finally, the group discussed the importance of introducing a general pre-emptive duty on those seeking authorisation, to avoid detention in a hospital through appropriate community provision where/whenever possible, and a requirement on them to describe how the authorisation of a detention is deemed to be a proportionate response to the circumstances.

3. Out of area and adult unit placements.

We acknowledge that occasionally these may need to occur where, for example, admission to an adult ward is necessary for a young mother to be cared for on a mother and baby unit with her child or young adult in work whose need are better met in a specialist adult setting. In such circumstances we recommend that the following additional safeguards should apply:

- that CQC should be notified within 24-hours of placement in an adult ward (as usually happens now) and out of area placements;
- that CQC records should include both the reasons for placement in an adult ward and/or out of area and the length of the proposed placement;
- that the review of the care plan should also include consideration of the need to remain in that placement;
- the first review of that placement should take place within 3 days of it happening in the case of placement on an adult ward and within 14 days of an out of area placement.

In addition to this, the Topic Group recognised the impact of travelling long distances on the recovery and ability of the family to support the child or young person post-discharge. To address this, we recommend the introduction of a new right to support (financial and/or practical) for parent(s)/carer(s)/family member(s) to visit the CYP who is placed out of area.

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B. Additional Issues

There are certain further matters that would be helpful to reinforce the recommendations made:

- the local authority (LA) and/or responsible authority for the area in which the CYP ordinarily lives or the responsible authority where the CYP is a looked after child should be notified if such placement (whether informal or not) extends beyond 28 days;
- any child admitted to a mental health facility should for that reason alone be regarded as a child in need under section 17 the Children Act 1989 and section 17 may need to be amended to include this as an example;
- any child who has been in a psychiatric hospital (whether informally or not) for a period of 28 days or more should receive section 117 after-care though this would need to be carefully aligned with LA duties under Part III of the Children Act 1989 – the group regard this as essential to prevent further crises and readmissions;
- the group highlighted the importance of effective transition planning and the need to ensure that all those who may be involved in the treatment, care, support and education of CYP should be aware of and involved in transition planning. The group's discussions acknowledged the limitations of current transition planning. This included the lack of alignment between health, social care and education services and between children's and adult services and resource limitations. However, the group's view was that effective transition is vitally important to the health and well-being of CYP and that proper preparation for transition needs to be the responsibility of all those involved in working with CYP;
- the group recognised the lack of data on CYP. It urges that the review consider that data on CYP is included as part of any wider recommendations made on data (eg that all data recorded is split into age groups);
- the group noted the uncertainties in relation to the definition of CYP since some legislation extends provisions for their benefit to the ages of 19, 21 or 25, particularly where a child is or has been in the care of the LA.

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C. Impact of other topic groups on CYP

The group's work cut across other topic groups and that was necessarily implicit in what we have written. Generally, the group has merely indicated any aspect of their work that may be relevant to other topic groups. Thus, for example, there are no recommendations in relation to ethnic, cultural and religious issues beyond observing that CYP need to be seen and understood not only as individuals but also within their family context. Other groups are much more qualified to make precise recommendations. The same comments apply in relation to Nominated Persons, advocacy, aftercare, autonomy and dignity and safety. Those groups need to bear in mind the role of parents (and sometimes other relatives) who hold Parental Responsibility under the Children Act 1989, as well as the position of LAs who hold a Care order. Members of the CYP topic group will be working with members of a number of these groups to ensure that CYP issues are appropriately identified and considered.

3. Rationale

The group was provided with submissions from the call for evidence, the focus groups and information on the particular legal issues and case law which impacted on CYP and also drew on their own experience and knowledge (which covered legal, charity, parent and carer and professional representatives).

This report both identifies the most important areas that require action as well as acknowledging other needs

Many issues which were considered are best addressed by better practice and training. The group's specific attention, however, was focussed on areas where government action is considered to be necessary they identified three key areas where recommendations could have a significant positive impact for Children and Young People and their families. In this context the group is particularly aware of the difficult position of parents who may be seen both as responsible decision-makers and as the primary source of care for the CYP. Those two roles can come into significant conflict in relation to issues like admission, treatment, care plans and discharge. These are areas very much for practice rather than legislation.

Scale/scope of the options/interventions

The recommendations will impact on CYP and their families.

It will extend safeguards to those informally admitted and clarify parental responsibility in relation to CYP with the ability to decide.

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Funding/costs

The extension of section 117 to CYP informally admitted is likely to cost money in the short-term but may also result in a benefit if it leads to fewer readmissions and a reduction in mental health crises.

Improving the safeguards for CYP informally admitted including formal reviews may also represent a cost though such formal reviews may lead to earlier discharge which could lead to savings.

The recommendations may result in decrease in informal admissions and consequent increase in formal detentions. This may lead to some increased costs but we would not expect these to be significant.

We would not expect there to be significant increase to LA costs in relation to the explicit inclusion of CYP under the definition of a 'child in need' as in practice this should already be happening.

Additional training to implement the group's recommendations and changes to forms, advice etc. will also incur costs. It is expected that these will be covered as part of the education, training etc. needed to implement the changes to the Act.

SOAD involvement in reviews is likely to require increased numbers, the recruitment, training and contracting of whom will be an additional cost.

The extension of the right of support for parents/families/carers to visit CYP placed out of area is also likely to represent a cost though we acknowledge that in some cases this support is already provided.

Support/challenge

We would expect these changes to be widely welcomed amongst practitioners and service users and their families. Providers may push back on the additional safeguards for those informally admitted

We would recommend that the recommendations are tested as part of the focus group process planned for the autumn.

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Dignity and respect

Clarifying the role of parental responsibility should improve both the experience of CYP and their parents under the Act as will the tightening of rules around placements in adult wards or out of area wards.

The additional safeguards for CYP informally admitted should also improve their experience and outcomes.

Detention rates

The group's recommendations on the role of parental responsibility in relation to detention, care and treatment is likely to increase formal detentions under the MHA and MCA. This is because CYP who might be admitted informally with parental consent will now be more likely to be detained.

Equality considerations, Black, Asian and Minority Ethnicities (BAME), Other

As set out above the group has not specifically considered issues in relation to other protected characteristics.

4. Implementation of recommendations

How would the recommendation be implemented? What levers would government and/ or the wider sector use to implement this change? Please consider:

- legislation would be needed to implement the requirements on increasing safeguards for informal admissions, to clarify the role of parental responsibility in admission and treatment and informing CQC of placements in Adult Wards.
- there will also need to be changes to practice in order to implement the recommendations which would need to be implemented by commissioners, providers of both health and social care and practitioners which would require changes to guidance, education and training.
- a range of organisations would need to be involved including DHSC to amend legislation, NHS England, Trusts and LAs to implement the recommendations and the CQC to monitor them.
- these recommendations do not have explicit inter-dependencies with other topic groups. However, improvement to the provision of care and treatment under the MHA should have a significant positive impact on the experience of CYP and their families.

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5. Evidence and analysis

As the interim report highlighted this found that 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 the care they received from 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.

The group also looked at case law in relation to CYP and parental consent and reviewed published data relating to the detention of CYP.

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Learning disability and autism

Chair: Gillian Baird

Working Group Lead: Viral Kantaria, NHSE

Secretariat: Amy Brodie, DHSC

Membership

- Carole Buckley, General Practitioner and Carer
- Zach Esdaile, Bowers Solicitors
- Hazel Griffiths, Service User and Carer Group
- Tim Gunning, Equality and Human Rights Commission
- David Harling, NHSI
- Mark Harvey AMHP
- Ashok Roy, Psychiatrist
- John Trevains, NHSE
- Theresa Joyce, Care Quality Commission

In addition to the core members, the topic group may bring in expert contributors for specific issues within the topic, or to test emerging findings.

Terms of reference

Remit

The interim report said the review 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

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- 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

The group will consider how current inequalities can be addressed in relation to the Mental Health Act, and any recommendations will consider the potential impact upon individuals identifying with protected characteristics under the Equality Act 2010. In particular, the review is seeking to address racial disparities, with a specific emphasis on people of African and Caribbean descent or heritage.

The purpose of this group is to identify potential recommendations the review could make, in relation to the above and to support the review's overarching goals (see below).

This group will not be duplicating work outlined in the Transforming Care Programme.

It will be important to examine the issues in the wider context and the overall system for children and young people. The review may be able to identify issues that impact the wider system and highlight these to government but detailed recommendations will be limited to the Mental Health Act setting.

A key task of this group will be to examine the call for evidence submissions to better understand how the Mental Health Act is applied for people with learning disability, to what extent it is being used to address unmet need in the community and how the Transforming Care Programme will address areas of concerns. There will also be some exploration of current guidance across the system about learning disability and autism as well as how this is implemented in practice.

There will be focused work on the inclusion of the learning disability and autism in the Mental Health Act. This will involve analysis into the original purpose, what the Mental Health Act is trying to achieve with this inclusion and examine if that is still relevant in today's health and social care system. The group will review arguments for and against the inclusion and what, if any, alternative models would need to be implemented to replace the legislative framework.

The group will also consider the review in Scotland of learning disability and autism in the Mental Health Act.

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Timing and outputs

The topic group will produce a short report, using the outputs template.

There will be four, half day meetings between June and August.

i. Review point:

Gap analysis and any additional research requirements.

Progress update to the review by 31st July 2018.

ii. Final report

The group will to produce a short report to the review leadership by 14th September 2018, using the agreed format, setting out key findings for consideration by the Review as they prepare their final report and recommendations to government.

The topic group's work will be supplemented by additional engagement activity.

Interdependencies

The topic group will need to consider the options development in other groups and assess if this could effectively apply to someone with or a carer for something with a learning disability and/or autism. More specifically, topics groups that will be of particularly interest:

- Patient autonomy
- Dignity and safety of the service user
- Advocacy
- Family/carer involvement
- Discharge and aftercare
- Procedural safeguards
- Tribunals
- Discharge and aftercare

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Goals set out in the review's interim report

- 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

Report

1. Issue

Overview of the topic:

There are specific concerns about the way the Mental Health Act (MHA) works for people with learning disabilities, autism or both which require that the needs of people with autism (ASD) with or without a learning disability (LD) or intellectual disability (ID) should be considered separately to the needs of people without either. However, there are also shared challenges.

Currently, the use of the MHA appears to be seen as '*an easier way out of crisis*' than finding good and appropriate care/placement for an individual with LD/ID and/or ASD/autism that meets their needs. We agreed with the view that behaviour in LD/ID and/or ASD can be and often is a manifestation of stress/distress from the mismatch of person, their environment and their experiences. There will be individuals who have co-existing mental disorders which are treatable which may also be present (and often difficult to diagnose) as may physical illness, and that an individual with LD/ID and/or ASD has a

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right to expert mental health assessment and treatment-as does the rest of the population. Individuals with LD/ID and/or ASD/autism should not be disadvantaged by any exclusions from the MHA and the legal safeguards within the MHA but require reasonable adjustments to care and environment that includes a skilled trained workforce, modified sensory environment and information presented in personalised accessible form. We heard evidence of absence of specialist placements and the reliance on generic hospital beds miles away from family although, the Crisp review reports that out of area placements are an issue for people with other mental health conditions.

We have also been told that an emphasis on 'best interests' use of the MHA (with compulsory detention) potentially may ignore the individual's wishes and participation in their care and their rights under the UN Convention on the Rights of Persons with Disabilities.

Much of the concern about the individuals with LD/ID and/or ASD/autism appears to be about their experiences of the implementation of the MHA rather than the legislation: a system not designed around the individual's needs nor operating within a culture that supports them. If detained, the experience of many but not all families, is of a system 'against' them, miles away, not concerned to support them or share their expertise and listen to them.

Timely discharge is a problem with several factors operating. We were told that 28 days may sometimes be insufficient time to diagnose and set a treatment plan for a co-morbid mental disorder in those with autism/ASD with or without LD/ID meaning frequent transfer to section 3 which is for 6 months (we discussed a 3 month review). We were told of no suitable local care placement; local clinicians not being willing to look after 'high risk' individuals and national financing that was not incentivising for local services to develop local care.

2. Findings

Recommendation 1 - Improve the data quality for detentions under the Mental Health Act of people with learning disabilities and autism to provide accurate numbers

Recommendation 2 - We recommend improving and strengthening existing safeguards following detention under the MHA and a framework to assess if these safeguards are being implemented properly. This should entail the following:

- a) Strengthen safeguards and support around admission
- b) Strengthen safeguards and support during section 2 detention and the treatment requirement for section 3

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c) Strengthen safeguards for section 39/41

d) Increased Autism/ASD and LD/ID expertise within the workforce

We have outlined how this should be implemented in the relevant section below.

Recommendation 3 - Individuals with ASD/Autism and Learning Disability LD/ID should remain within the scope of the Mental Health Act for assessment of co-existing mental health disorders when the individual's behaviour puts the individual or others at immediate risk of significant harm (this includes abnormally aggressive or seriously irresponsible behaviour). Consideration of other causes of such behaviour should be part of assessment.

Recommendation 4 - The Code of Practice should be amended to highlight specific issues in LD/ID and/or ASD/autism and that the Act should be used with caution in this group.

We have outlined how this should be implemented in the relevant section below.

Recommendation 5 - Professionals within the scope of the MHA should undertake mandatory training about neurodevelopmental disorders including LD/ID and/or ASD/Autism as well as continuously informing their approach to care through 'expert by experience' liaison groups and the families/ carers knowledge of their young person (including necessary adjustments, the sensory and social environment, recognition of arousal states etc).

This should also incorporate sharing settings where good practice exists across the country, thereby setting the benchmark for wide scale change.

Recommendation 6 - Commission (an explicit requirement) services to support the needs of people with LD/ID and/or ASD/Autism with behaviour that challenges and their families before they reach crisis and after any crisis with all age care pathways starting in childhood through transition to adult life.

Recommendation 7 - Extend the statutory nature of the Code of Practice to health commissioners by amending legislation to make the MHA Code applicable to CCGs, NHS England and local health boards and trusts in Wales on a statutory basis as it is for professionals and LAS

Recommendation 8 - Integrate all the various complicated but relevant pieces of legislation

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3. Rationale

Recommendation 1 –

The Mental Health Act Services Dataset has recently started to collect data in relation to detentions for people with learning disabilities and autism. As this is new requirement within this dataset, there are concerns about the quality and quantity of the data.

We acknowledge that the Learning Disability Services Dataset collects some data about inpatient admission in addition to CQC data. There doesn't appear to be any reliable ASD data. However, there should be one source of data which could be through nationally administered database available to commissioners, clinicians and the public.

In addition, the level of data available is limited and doesn't address some of the concerns, particularly around extended hospital stays.

Recommendation 2 –

The issues that have been outlined above could be resolved or mitigated through better safeguards for all which would equally benefit those without LD/ID and ASD/Autism. We have not engaged with other topic groups to determine what these would be.

Through the experience of those in the group and the surveys that we hosted, we have produced a clear list of safeguards we think would particularly benefit people with LD/ID and ASD/Autism. This is outlined in detail in the implementation section.

Recommendation 3 –

Many expressed the view to us that removing LD/ID from the MHA could disadvantage individuals with LD/ID and/or ASD/autism who may find themselves at greater risk of prison.

Many of the objections to the MHA are not about the definition/classification of ASD/autism (mental disorder or not mental disorder) but are about standards, code of practice, adherence to guidelines, alternative options etc. Changing the classification might not make any difference to how individuals are treated, just the setting in which this occurs.

We were not convinced by the view that removal of LD/ID and autism from the MHA would ensure the development of better alternative care provision although our top priority is prevention and hopefully making detention for those with LD/ID and or autism an exceptional circumstance.

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We concluded that there are a small group of individuals with ASD or LD/ID (with or without autism) who may present in behavioural crisis and require a safe place and assessment even if preventive services meeting needs were to be much better than they currently are.

It's important to note this recommendation reflects the majority view of the group, there were members who clearly and passionately expressed their view that LD and Autism should be removed from the scope of the MHA.

However, all agreed that admission to a hospital through the MHA has to be justified as the best/only place for assessment to take place. The presenting behaviours may meet the MHA criteria of abnormally aggressive or seriously irresponsible but we favoured 'behaviour resulting in imminent risk of significant harm to self or others'.

Assessment of additional mental health disorders needs to be by those with specific training and skill in ASD and/or LD. Stressed behaviour in ASD/LD can appear to be psychotic, catatonic, with inappropriate affect eg giggling, thought disorder/hearing voices (common in ASD) resulting in misdiagnosis.

We agreed that the reported experiences of some families with a young person with LD/ID and/or ASD was of trauma and often worsened behaviour in the individual. However, there are also families who have experienced good care in specialist settings for autism/ASD and LD and this need to be the experience of all.

We support the view that autism without any co-existing mental disorder or abnormally aggressive or seriously irresponsible with imminent risk of significant harm to self or others should not be a reason for enacting the MHA.

Our considerations are outlined in more detail in Annex 1.

Recommendations 4,5 and 6 –

We have detailed clear actions that the group has discussed and agreed should be implemented.

Recommendation 7 -

NHS commissioners (CCGs and NHS England) have an important role in Transforming Care: they are the ones commissioning beds in inpatient units and could be held to account for their role in commissioning local special services for individuals with LD/ID and/or ASD/Autism that might prevent the need for detention and appropriate placement/services for early discharge.

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Recommendation 8 –

We discussed how the different legislative frameworks can make it difficult for professionals and families to interpret or know about the care that should be delivered for individual needs.

There were two primary concerns which we felt should be handled separately.

Firstly, the legislation around capacity, deprivation of liberty, compulsory and voluntary admission would, ideally, be seamless across the different age ranges. We recognise the case that will be heard by the Supreme Court on October regarding parental consent and the Mental Capacity Act (Amendment) Bill which currently being passed through parliament.

Voluntary admission to a local unit is the most desirable approach but a deprivation of liberty authorisation is likely to be needed on safeguarding grounds. Our understanding is that this can only happen in care homes/hospitals unless there is approval from the Court of Protection. There was a discussion about how this means there is a gap that does not facilitate local step up – step down approaches which could be accommodated locally and used voluntarily by patients and families. However, the group accepted there could be unintended consequence of informal admission of this type because of the reduced legal protections available for the individuals.

Secondly, despite many Acts and reviews, the issue of poorly integrated health, social care and education services for individuals with complex needs remains. The issues that we identified were:

- Varying eligibility within the Care Programme Approach
- Geographic variation
- Workforce that lacks training in and understanding of ASD and LD
- Wholly inadequate housing and/or accommodation for the range of needs.

The current approach to legislation has been piecemeal and has tried to be addressed through various Acts. We have highlighted in the implementation section which Acts we believe this relates to. We also believe that there needs to be a clear and explicit link to equality, human rights and disability legislation.

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Criminal Justice System

We discussed the criminal justice system (CJS) but as a group agreed this would need much further consideration. Therefore, we have not made detailed recommendations.

We were told that about 50% of long stay patients in hospital have committed crimes, 7% of people in prison in the UK have ID and about 30% in prison in other countries where there is no access to hospital diversion have ID. We are aware that whether an individual is detained in a forensic or non-forensic bed depends on local disposal rather than the act committed by the individual.

We are aware of the professional view that any change in the scope of the MHA with regard to LD/ID and/or ASD/Autism may result in more individuals with ID/LD and/or ASD/Autism in the CJS and possibly prison to their detriment (vulnerable to other inmates, no reasonable adjustment to environment; little or no specialist training; uncertainty re process).

There was a view that there should be more use of community options at sentencing. There was also another view that criminal acts should be dealt with by the courts and the individual with ASD/Autism, LD/ID or both should be diverted to mental health services via sections 39/41 which could be better than MHA detention under section 3.

Our recommendation about the expertise of the workforce is intended to include the CJS and prisons.

4. Implementation of recommendations

Recommendation 1 -

The Mental Health Services Dataset should include the number of detentions, the section used, length of stay, age, sex, and other protected characteristics. It would also be helpful to include the degree of learning disability, other neurodevelopmental disorders; physical health; comorbid mental health conditions etc. This could be through nationally administered database available to commissioners, clinicians and the public.

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Recommendation 2 –

This recommendation should be implemented through changes to both the MHA and its Code of Practice.

We suggest the following measures:

a) Strengthen safeguards and support around admission:

- Care and Treatment Reviews (CTR) should have been carried out prior to admission or in anyone with LD/ID and/or ASD/autism in whom admission is contemplated. The justification for hospital admission should be clearly stated.
- Using Section 2 of the MHA (or similar if CJS diversion) for detaining individuals with LD/ID and/or ASD/Autism for assessment unless there is recurrence of a known co-morbid mental disorder meeting treatment criteria
- A regular audit of AMHP and Medical reasons for admission to detention. We would expect this to include the individual/families wishes and feelings, rationale behind detention, explanation of whether or not care could be delivered in the community and if it could, why is this not suitable.
- Reasonable adjustments should be made to accommodate an individual's bespoke needs and consideration must be given as to whether or not the environment of detention is suitable. This may require more specialist provision.

b) Strengthen safeguards and support during section 2 detention through:

- Automatic IMHA Advocacy requiring opt-out and have relevant expertise. This is dependent on Local Authorities commissioning advocates.
- Full review of the individual to be mandatory by 2 weeks with a Discharge/ Treatment and Care Plan expecting that the period of assessment for 28 days is sufficient. Review to include local MH and 'implementation' team member from Clinical Commissioning Group with clear justification and treatment criteria for continued detention in a hospital.
- Ensure information is provided to all individuals and families in a way personalised for their needs which may involve pictorial presentation, appropriate language translation etc.
- Ensure information is given to families after as well as at admission including a right to external and independent expertise in ASD/LD and challenge to delayed applications for discharge and any proposal for further detention.

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- If a treatment order is proposed, the treatment criteria for hospital detention needs to be very clear with the intended outcomes and timescales. This should be reviewed and be able to be challenged by someone with appropriate clinical expertise.
- Reviews should be conducted by Tribunals and not the Hospital Manager.
- Physical health should be reviewed by qualified practitioners including vision and hearing checks (if not previously done) and we support the current work being undertaken by NHS England to ensure this happens.

c) Strengthen safeguards for section 39/41

- The safeguards discussed above should apply to those under sections 39/41 and Part 3 of the MHA.

d) Workforce

- Address the current workforce shortage of training in ASD/LD for all mental health professionals to ensure the appropriate specialism and expertise in learning disabilities and autism. This should also include experts by experience.

Recommendation 3 –

The MHA needs to be amended and this would also need to be reflected in the Code of Practice, all guidance documents and in training.

Recommendation 4 -

- Both ASD/autism and LD/ID are risk factors for other mental and behavioural disorders (see appendix 4) which may be difficult to diagnose and may present with behaviour that is “abnormally aggressive and seriously irresponsible behaviour” with imminent risk of significant harm to self or others as well as with emotional withdrawn behaviour.
- However, such behaviour may be, and often is, a manifestation of stress from a mismatch of person and environment and experiences resulting in behaviour which can look psychotic, catatonic, inappropriate affect eg giggling, thought disorder/hearing voices (very common in ASD) resulting in misdiagnosis.
- MHA should be used with caution in LD/ID and/or ASD/autism and justified on grounds of considering and assessing whether an individual has a co-existing additional mental disorder and/or behaviour 'that is abnormally aggressive or seriously irresponsible and puts the individual or others at imminent risk of significant harm'.

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- Where possible assessment should be carried out at the individual's home or specialised local placement by a team expert in functional analysis of behaviour and with skills in LD/ID and ASD (the crisis team in rec 1 and skilled psychiatry) in a place close to family that understands ASD/Autism; has Trained staff; a low arousal environment etc and CTR conducted.

Recommendation 5 –

We recognise that this recommendation would require significant change not only to how it is implemented but it needs to be accompanied with a change in culture.

The training should include:

- How behaviour in ASD and LD can be a manifestation of stress from mismatch of person and environment and experiences resulting in behaviour which can look psychotic, catatonic, inappropriate affect eg giggling, thought disorder/hearing voices (v common in ASD) resulting in misdiagnosis.
- The importance of recognising the association comorbidities eg of neurodevelopmental disorders including ASD in those admitted with MH illness and no other diagnosed problems.
- Making reasonable adjustments to accommodate communication needs of these conditions
- Hospital staff should recognise the expert knowledge of families about their son/daughter and take a partnership approach to care.

We suggest that the training could be further supported and facilitated by **experts by experience** who can advise and monitor the physical environment for ASD and LD. The expert by experience could assist the local CCG with strategic commissioning for ASD/LD services and visiting services to provide bespoke advice. For example, they could highlight the need for a quiet space (not to be confused with segregation- a punishment), lower sensory challenges; and treatments; learn to be alert to signals of arousal and back off.

Recommendation 6 –

All services should set up a local joint services strategy group including experts by experience and a local implementation group with responsibility for oversight and accountability for the local population.

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Remove the perverse financial incentive for extended hospital stay rather than discharge to community care. Transfer financial responsibility for payment for in-patient beds to CCGs/LAs giving back national specialist money for beds but ring fencing it. The costs of decommissioned beds must move to community services without delay with bridging arrangements if needed.

Set up a Care Treatment Review and Care Programme Approach hybrid for all ages and this should have the same statutory footing as the Education Health and Care Plan to review the clinical support plan for the individual and family, assess risk to self and others, and identify further needs and make a crisis plan.

Recommendation 7 -

We suggest amending section 118 of the MHA 1983, both to expand the scope of the Code of Practice and to require NHS commissioners to have regard to it.

Recommendation 8 –

There are several pieces of legislation which can have an impact for people with LD/ID or ASD/Autism and we suggest that consolidating the law should take place in two different ways.

The first, is to consolidate the law around capacity, compulsory detention and voluntary admission. This would include the MHA with the Mental Capacity Act and Deprivation of Liberty of Safeguards.

The second, is to consolidate the law to provide for better integration of health, social care and educational services for those with complex needs. This includes the Care Act, Children and Families Act, Autism Act as well as the Special Education Needs and Disability Code of Practice.

5. Evidence and analysis

We referred to the call for dedicated evidence pack that was produced by the civil service secretariat team. In addition to this, we conducted three dedicated surveys across various networks: Royal College of Psychiatrists, Professional Social Workers, Approved Mental Health Professional and a parent's forum. The survey's explored why and how the MHA is being used for people with learning disabilities and autism, whether autism and/or learning disability should remain with the scope of the MHA as well as alternatives to detention.

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Throughout the course of the summer, each topic group member used their own networks to discuss issues and test our thinking. This was feedback was fed back at our meetings.

Annex 1: More detail about the arguments for and against autism/LD remaining in scope of the MHA

Autism:

Reasons for change:

- In theory autism could be sole reason for admission under the Act (although the ASD disorder must cause some sort of risk to the person or other persons, cannot be assessed or managed without being in hospital and the person does not agree to admission). However, it is unlikely that this would happen. This is regarded as — indirect discrimination Equality Act section 19 and Committee Rights of Persons with Disabilities (CRPD).
- It is co-existing disorders in ASD without LD that are problematic. Individuals with autism and a co-existing mental health disorder who need assessment for the latter and who meet the criteria of the MHA should have the same rights to be admitted/assessed and treated under MHA like anyone else but with appropriate adjustments for their ASD and/or LD which is clearly not happening (an Equality Act requirement).
- ASD is now classified as a neurodevelopmental disorder –other ND disorders are not separately listed in the MHA although often associated with other mental disorders
- Articles 3,5 and 8 for Human Rights and Equality Act section20 currently transgressed by implementation of the MHA.

Reasons against change:

- Some individuals with Autism with or without LD/ID find themselves in crisis and need a 'safe space'. Reasons may be multifactorial; some may be experiencing an exacerbation of symptoms of autism during adolescence, circumstances may have changed eg school/college/family/accommodation, there may be another mental health disorder—or a medical/physical problem etc. Assessing which of these is contributing to the behaviour is not always easy and other disciplines may need to be involved. This approach is what is offered for any individual without ASD so not to do so is discriminatory.

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- There is a concern that if autism is removed from the MHA, individuals who have co-existing ASD will find their ASD needs ignored (including those with a mental health disorder who are then found to have ASD). There is a risk that services will refuse support for those with ASD because it is 'just the autism' and is not covered by the Act. There will be a denial of responsibility which currently occurs in mental health services.
- We were advised that more people with autism may find themselves in the CJS if autism is removed from the MHA. When people with ASD react adversely to unfavourable environments there is a strong likelihood that they will be seen to be behaving with intent and this behaviour could be criminalised with the consequence as they enter the criminal justice system that their needs will not be recognised or met.

LD/ID with or without ASD/autism

Reasons for removal from the MHA:

- Strong views from families that hospital is never the right place for the individual and generally makes behaviour worse — that is the lived experience
- Inappropriate treatment eg anti-psychotics used/insistence on groups/seclusion as punishment
- No understanding of ASD or LD/no skills in assessment for treatable mental health condition as differential diagnosis requiring functional analysis
- Neglect of physical health
- Misdiagnosis of mental disorder
- It will force alternative and better provision to be developed
- Individuals get stuck and discharge delayed
- Often miles from home: human rights breached –see above

Reasons against removal:

- No other provision for assessing mental illness in LD which is difficult
- No other provision for LD plus abnormally aggressive behaviour causing damage to self/others and the concern that this would push people into the CJS
- If people with LD and autism are removed from scope of the MHA, it is unclear how should their rights be protected if they are admitted to hospital for inpatient treatment?

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- Issues such as distance are nothing to do with legal classification. This has been well-documented in the FYFVMH; Lord Crisp Report and we accept that NHS-E are addressing this.

Annex 2: Summary of survey responses

Royal College of Psychiatrists

90% experienced lack of an alternative and 'least restrictive option'.

Overwhelming majority used section 2 for ASD, LD and LD plus ASD.

One third commonly converted section 2 to 3 for ASD alone with nearly half for LD with or without ASD (just under half not sure).

50-90% would have preferred to use an alternative to the MHA and thought intensive community support would have prevented admission.

Respondents evenly split between statute and code of practice for giving CTR 'muscle'.

Additional safeguards of automatic referral to Tribunal for review, advocacy and accessible information all supported strongly.

Lack of autism specialist placements agreed by all plus training.

44% agreed, 30% disagreed others not sure about extending the behaviour caveats of LD/ID to autism.

Nearly all thought discharge of LD/ID and/or ASD delayed compared with others nearly always because of lack of accommodation and limited financial resource (sometimes because of worsening behaviour).

In response to the question 'If Autism were removed from specific mention in the MHA, how would that affect how persons with Autism and LD/ID were managed?' most thought no change but some concern that the autism would not be recognised.

In response to the question 'If Autism were removed from specific mention in the MHA, how would that affect how persons with Autism were managed?' the responses were more varied with some suggesting that autism might be used as an exclusion for mental health access; that those with ASD would miss out on treatment; that more would go to the CJS but others commented that the additional mental disorder would need to be more tightly defined and there could be more use of the MCA.

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In response to the question 'If the MHA proviso for learning disabilities 'having abnormally aggressive behaviour or seriously irresponsible conduct' were removed, how would that affect how persons with learning disabilities were managed?' there were a range of responses for, against and not sure; some suggesting that there would then be a need to develop better local resources for challenging often risky behaviour; some saying that it would lower the threshold for detaining those with LD; some saying more individuals would end in the CJS; some saying that detention can be because of families/local facilities not coping and that the behavioural caveats should never be a reason for admission without the possibility of an additional mental disorder to be assessed (which can be difficult to diagnose).

Principal Social Workers Network

60% said that MHA use could have been prevented with suitable intensive community support.

Many did not think CTR would prevent detention as it happens too late in the process but in combination with a good CPA process it might do—again lack of resource quoted. Respondents equally divided between statute and code of practice for CTRs.

Automatic advocacy, Tribunal and easily accessible information all needed for better safeguards following MHA detention.

Barriers to discharge: both lack of community care and financial gain to often private hospitals: cap the latter; develop more short term local crash pads and a closure of beds has resulted in more people having to get to crisis. A persuasive quote: 'The barrier is the money is not transferring in a planned proactive way from hospital to the community to ensure there is the right level of joined up clinical and social care expertise to meet and manage needs in a community setting'.

In response to 'If autism was removed from specific mention in the MHA, how would that affect how a person with autism was managed?' Concern was expressed that those with ASD would be diverted to the CJS, would not get their needs met but others said that there should be a focus on additional mental disorder for the MHA currently anyway. Many described the presenting problem as being behaviour so there was a majority of support for including autism/ASD in the current LD/ID behaviour caveats of the MHA.

Removal of the LD/ID caveats was thought likely to result in increased admission of those with LD/ID due to a lower threshold or diversion to the CJS. Others commented that Deprivation of Liberty Safeguards/MCA could be used or court of protection — all expensive and time consuming.

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Overall concern about CJS for those with autism/LD/ID, not assessing additional MH disorder; what to do if serious risk to others and lacking capacity? General comment that sect, followed by 3 and no improvement is not helpful and what is really needed is better management through better understanding of LD/ID and /or autism/ASD in the community.

Agreement about lack of specialist placements and deleterious effects of placing LD/ID and/or autism in general wards/hospitals. There was also an agreement about delayed discharge due to lack of accommodation and local services.

Parent survey

The parent survey overwhelmingly wanted autism and LD removed from the MHA as a driver to better services and avoidance of trauma to the individual. Many recounted their negative experiences of the process of detention and were clear in their view that detention in hospital was harmful. There were fundamental views that autism and/or LD was not a mental disorder. However, if individuals with ASD or LD/ID were to be detained with the MHA they wanted much better safeguards and there needed to be better training and expertise of professionals.

Other parents spoke more positively of experience in specialist hospitals. There was not a consensus amongst parents if hospital is ever the right place for a person with learning disabilities and autism, one person expressed a few that it was the only way to save their life.

Annex 3: Personal reflection from one carer representative on the topic group:

Autism should be removed from the scope of the MHA. We cannot conduct this part of the review of the MHA without referring to the Winterbourne review. Winterbourne was not an isolated scandal. We are still hearing of similar issues and despite me asking during the code of practice review in 2015, for issues winterbourne identified to be addressed, families are still reporting unacceptable and unsafe care, under MHA. I therefore, recommend urgent end to Winterbourne style model of care. It is abundantly clear that long term admission to specialised Assessment and Treatment Unit (ATU) is not appropriate and using the Act to ensure this happens. Should be patient led/needs not service led/needs instead, families request a safe therapeutic, short stay, de-escalation space, where families are not pushed out of their care. Extra scrutiny of the independent sector and NHS FT LD/ASD subsidiaries that hold onto SU longer. We cannot guarantee Su safety and quality of care, poor definition and understanding of what is meant by abnormally aggressive behaviour. Too often individuals are admitted because their social care providers are failing to meet needs. Or poor respite and carers become exhausted. Even when this has been identified, seems to be no way to ensure commissioners provide

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these and admission to hospital is the fall-back position. We also need to see a change in language, current terminology locates the problem within the individual, rather seeing distressed behaviour as communication. I'm not convinced professionals understand or accept autism, how best to communicate. Families reporting concerns around treatments and we have seen the need for STOMP. Families are wanting extra due diligence and policing, urgent cultural changes in psychiatry.

Annex 4: How services can/should support people with a learning disability or autism in ways that avoid the need for detention, including responses to challenging behaviour

We attached the highest importance to effective preventative intervention services for individuals with challenging behaviour from any cause or circumstance from childhood through transition to adulthood and particularly at crisis points but focussed on the prevention of crisis. We accepted that our suggestions would fall outside of scope of this review but we wanted to share and note this discussion.

There should be a joined up and integrated processes and services with a skilled and trained workforce from health, social care and in those under 25, education. We suggest making the following changes:

- Transfer financial responsibility for payment for inpatient beds to CCGs/Las. The costs of decommissioned beds must move to community services without delay with bridging arrangements if needed. Use the SEND/EHCP process to identify those with LD/ID and/or ASD/autism with behaviour that challenges (local Joint Strategic Needs Assessment).
- Commission a trained challenging behaviour (CB) team and focus on all 12 - 20 year olds (it could be 16 - 18 year olds initially) in a CCG locality with CB with intervention plan.
- At annual review for people with autism or LD, this should include a review of behaviour using a standard measure.
- Set up a CETR/CTR/CPA hybrid for all ages on the same statutory footing as the EHCP to review the clinical support plan for the individual and family, assess risk to self and others, and identify further support needs and make a crisis plan.

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- Develop local step up/step down placements both day care and beds for all ages with committed skilled medical/functional etc assessment. Develop housing for a range of needs inclusive of supported accommodation able to respond to crisis needs of people with a LD/ASD, locally available, supported by experienced staff and readily able to be flexible with complex and sometime rapidly changing needs.

Early prevention is critical and should begin before adolescence. Most children and young people with LD and/or ASD with challenging behaviour should have been identified through the SEND process and have an EHCP with designated needs as emotional, social and behavioural as well as cognitive and learning. The SEND process should be enhanced to require CCGs to keep a record through the EHCP of children over the age of eg 8 years with behavioural SEND needs.

Every EHCP with emotional social and behavioural needs identified should include a plan to reduce the behaviour problems at school and at home (currently little support at home in EHCP) and measure outcome. Provide social care eg through short breaks—currently totally inadequate. Ensure appropriate education that does not stress the child or young person. In some cases, a 24 environment and curriculum may be needed.

Every CCG group or groups should develop a multidisciplinary multiagency team with skills in challenging behaviour in LD and/or autism including skills in communication in LD /and/or autism and can carry out functional analysis. It requires real expertise and such teams do not exist except in a very few places (ideally joint health paediatrics, psychiatry, psychology SLT and nurse commissioned team skilled in LD/autism). This team should ensure the provision of joint/integrated protocols between relevant agencies that assure post-assessment support, a critical factor in replacing challenging behaviours with more normative and purposeful pursuits. With this level of staged input, change of school if needed, short breaks, different activities through school hols etc. it is anticipated that challenging behaviour can be reduced and families less exhausted.

Warning signs for behaviour escalation should be monitored and the CB team called in for review eg CTR, assess and intensively support working closely with Community teams for LD and for MH to ensure provision of ongoing support to provide assessment and treatment in the least restrictive environment

If behaviour does not improve and the child or young person is a danger to self or others CB team moves to step-up and considers day care in a purpose developed unit locally. This would include consideration of sensory environment, staff expertise, activities all designed to minimise stress. Skilled medical input necessary to ensure physical and mental health assessed and treated.

If home care crisis persists and staying at home is not possible, the next stage is to consider overnight placement.

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There is also a lot of consideration about the transition from children to adult services. There is urgent need for local alternatives to living at home as the young person gets older (a home for life) but needs to be highly specialist high quality residential care for those with LD and autism.

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Interface with Mental Capacity Act

Chair: Aswini Weeraratne QC

Working Group Lead: Alex Ruck Keene, Barrister

Secretariat: Amy Brodie, DHSC

Membership

- Ruth Cairns, Psychiatrist
- Steve Chamberlain, AMHP
- Lorraine Currie, Shropshire County Council
- Clementine Maddock, Psychiatrist
- Jessica Major, DAC Beachcroft
- Richard Murphy, NHS Solent
- Carole Murray, Service User and Carer Group
- Carolyn Taylor, TV Edwards Law

In addition to the core members, the topic group may bring in expert contributors for specific issues within the topic, or to test emerging findings.

Terms of reference

Remit

The interim report said the review 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 Deprivation of Liberty Safeguards (DoLS)/the MHA

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- The specific legislative issues identified as falling for consideration by the Review in the Government's response to the Law Commission proposals for reform of the Mental Capacity Act (MCA) and DoLS
- 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

The group will consider how current inequalities can be addressed in relation to the Mental Health Act, and any recommendations will consider the potential impact upon individuals identifying with protected characteristics under the Equality Act 2010. In particular, the review is seeking to address racial disparities, with a specific emphasis on people of African and Caribbean descent or heritage.

The purpose of this group is to identify potential recommendations the review could make, in relation to the above and to support the review's overarching goals (see below).

It is likely that, if only for practical reasons, the topic group 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.

The topic group will explore the interface with an overall aim of testing recommendations that are, as far as possible, guided by simplicity.

The topic group will explore whether there are any relevant definitions of deprivation of liberty or relevant dividing lines between mental health and mental capacity legislation in other jurisdictions.

In addition, the topic group will consider what the correct legislative response is to address the position of those in emergency departments whom staff consider should remain present there for purposes of assessment, but who do not fall within the scope of s.5 MHA. In this, the group will consider, in particular, whether the Law Commission's proposed creation of a stand-alone provision for emergency deprivation of liberty for those lacking the relevant decision-making capacity is the correct response.

Timing and Outputs

i. Review point:

Gap analysis and any additional research requirements by 16th July.

Progress update to the review by 31st July 2018.

These are working documents produced by the Review's sub-groups. Please note that document style may therefore vary. See the Review's conclusions and recommendations in its final report, **Modernising the Mental Health Act: Increasing choice, reducing compulsion**

ii. Final report

The group will produce a short report to the review leadership by 14th September 2018, using the agreed format, setting out key findings for consideration by the Review as they prepare their final report and recommendations to government.

The topic group's work will be supplemented by additional engagement activity.

Interdependencies

- Maximising Patient Autonomy
- Detention criteria
- Advocacy
- Tribunal, hospital managers, renewals
- Family / carer involvement
- Community Treatment Orders
- Discharge, care planning and aftercare
- Learning disabilities / autism
- Criminal justice system and 'Part 3' of the Act

Goals set out in the review's interim report

- 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

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

Report

1. Issue

The Mental Capacity Act 2005 (MCA) stands alongside, but in principle is entirely distinct from, the MHA. The MCA relates to a person's functioning and ability (capacity) or inability to make a particular decision. This is different to the MHA which relates to a person's status as someone diagnosed as having a mental disorder within the meaning of the Act and subject to its powers of compulsion. Overall, the MCA covers all decision-making, whereas the MHA 1983 is, to a very large degree, limited to decisions about care in hospital and medical treatment for mental disorder.

A key interface of the MHA and MCA is 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 (whether admitted directly to psychiatric setting or transferred from the community) but do not have capacity to consent to that confinement, and who are therefore considered to be deprived of their liberty. In order to be deprived of their liberty, professionals must follow procedures called the Deprivation of Liberty Safeguards (DoLs). There is significant criticism about the effective use of DoLs, which has been made more challenging following the 2014 Supreme Court decision in *Cheshire West*⁶³, which widened both the commonly understood scope of the definition of a deprivation of liberty and the range of places to which it applied. 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. The Review has also been concerned as to how practical issues with DoLs are impacting the recent trend of increased the use of the MHA as a – practically – easier alternative. Although precisely how these factors interrelate, and what role other factors may play, is not straightforward, it is clear that there is now a

⁶³ P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council & Anor [2014] UKSC 19.

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greatly reduced place for informal patients in the mental health setting, without consideration of the potential impact that this has for a service user who is seeking help for their mental health needs.

During the life of the Review, the government responded to the Law Commission's Mental Capacity and Deprivation of Liberty report addressing DoLS, by introducing the Mental Capacity (Amendment) Bill into the House of Lords. The timing of this legislation has led to some complexity in the topic group's work. The government had previously indicated that it would await the Review's recommendations upon a number of issues and respond legislatively in the Bill. However, it became clear that this would not be possible. Further, there may well also be amendments to the Bill as it goes through the Parliamentary process, from Government or elsewhere. The topic group has therefore proceeded on the basis that the Bill will be enacted in the form as it stands before Parliament at 14 September 2018.

For the longer term, the Government (in its response to the Law Commission report) also asked the Review to consider, and the Review leadership separately had already been concerned to understand, whether the future of mental health legislation should be 'fusion'. As set out below, 'fusion' which, upon inquiry, turns out to be a term with multiple different meanings.

2. Findings

Recommendation 1 – The MHA should provide that a person can consent in advance to confinement for purposes of receiving medical treatment for mental disorder, or to empower an attorney to give consent.

Recommendation 2 – In the case of inpatient admission and/or treatment for mental disorder, use of the MHA should be predicated upon whether a person is objecting to their admission or treatment necessitating the use of compulsory powers. If the person lacks capacity to consent to their admission for those purposes, and is not objecting, then only the MCA should be available.

Recommendation 3 – There needs to be clarity as to what legislative powers are available to require a person to remain in A&E for their own safety pending assessment for admission under the MHA 1983. To give that clarity, the Review leadership will need to choose whether to extend s.5 MHA or to rely upon the proposed extension of s.4B MCA contained in the Mental Capacity (Amendment) Bill.

Recommendation 4 – The MCA should be able to authorise a deprivation of liberty under the LPS encompassing, where it arises, the risk of harm to others, but the LPS should not be the primary mechanism for authorising deprivation of liberty for public protection.

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Recommendation 5 – There is merit in investigating a future direction of travel for mental health legislation which is judged by reference to the relative importance of individual autonomy against legal certainty. More work is required to carry out this investigation.

3. Rationale

Recommendation 1: the topic group considered, but ultimately rejected, giving a statutory definition of deprivation of liberty which would narrow the definition given by the Supreme Court in *Cheshire West*. It did so because it considered, whilst there may well be grounds upon which legitimately to narrow that definition in other settings (for instance a person's own home), those grounds were unlikely to be applicable in the context of admission and treatment for mental disorder. The consequence of this is that the topic group considered that there were no proper grounds upon which to turn back the clock to provide that those lacking capacity to consent to their admission could routinely be admitted as informal patients.

However, the topic group considered that enabling a person to give advance consent to confinement for purposes of admission to be treated for mental disorder served two important goals for the Review: (1) giving a legitimate basis (even if only applicable in a relatively small number of cases) to enable informal admission even in the case of those who lose capacity to consent; (2) providing a driver to secure advance care planning in the context of those with fluctuating capacity. Such advance consent could not serve as a direction to professionals to admit, or to provide specific care and treatment; rather it was a framework for considering the position where the relevant professionals considered that admission was required. The topic group were clear, however, that implementing this recommendation could only be done if the recommendation that advocacy be provided to all informal patients also be implemented, as such was necessary to secure against the potential for abuse of these provisions. The topic group also considered that the provisions relating to advance consent should be implemented in the form recommended by the Law Commission, as these provided a statutory 'let out' to ensure that a person could not be bound by their consent in circumstances where it would be unconscionable to do so.

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Recommendation 2: the topic group considered, but ultimately rejected, a considerable number of options in relation to the interface question, recognising – as was strongly identified by stakeholders – that any solution in this context could not be entirely satisfactory, (1) because the MCA and the MHA were so different in terms of their approaches, safeguards⁶⁴ and entitlements; and (2) because of the difficulty of imposing a (necessary) binary legal classification upon the complex realities of individual patients.

Having conducted a targeted engagement exercise, the topic group ultimately considered that the necessary balance between discretion (required to reach the right decision in any individual case) and clarity (to ensure minimum ambiguity) would best be served, at least in the short to medium term, by continuing to maintain 'objection' as the dividing line, as at present, but by changing the position in DoLS/proposed in the LPS to provide that if a person is not objecting, only the LPS could be used. Providing that only the LPS could be used in non-objection cases would, further, serve as a potential measure to halt the increasing use of the MHA, especially where combined with robust care planning to minimise crisis admissions to hospital from the community.

The topic group further considered that advantage should be taken of the fact that s.4B MCA (if amended as anticipated as at 14 September 2018) would provide a window of time within which it would be possible lawfully to deprive a person with impaired capacity of their liberty where necessary (in essence) to secure their life and limb. The topic group considered that such window could and should be used to identify the reasons for, and whether a person – in particular a person with cognitive impairments – was, in fact objecting to either their presence in hospital and/or for their treatment for mental disorder, it being important that the person be provided with the support required to enable them fully to participate in the process. The topic group considered that this window should be limited in time, a provisional view being expressed in favour of 72 hours, by way of analogy with s.5 MHA.

Reflecting views strongly expressed both by the topic group and by stakeholders, the topic group consider that guidance will be required (in the Code of Practices to both the MCA and MHA) as to the identification of a material objection for these purposes, drawing upon the case-law in the Court of Protection (in particular *Re RD* [2016] EWCOP 49) identifying the test for the – analogous – purpose of identifying when a person subject to DoLS wished to exercise their right to challenge a DoLS authorisation.

⁶⁴ Including as to treatment and access to review by a tribunal (in relation to the latter, that there is no automatic referral to a tribunal after a fixed period of time for a patient subject to DoLS/the LPS, by contrast with the position for a patient detained under the MHA).

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With one exception, the topic group left primary consideration of the question of whether the MHA should provide stand-alone authority to deprive a person of their liberty outside hospital to other groups more directly concerned with these issues (in particular the CJS and CTO groups). The topic group did, however, consider that it was sufficiently clear from the place of s.17 MHA in the statutory framework of the MHA that there was no obvious purpose served by requiring s.17 to be used alongside DoLS/the LPS in the community. If parallel authorisation is to be required in other cases (for instance guardianship, CTOs or conditional discharge), then the topic group considered it important that patients subject to both regimes should be able to challenge their position as quickly and effectively as possible, the obvious solution being 'double-ticketing' to enable one person to sit as both an MHT/MHRT legal chair and a Court of Protection judge in a relevant case.

Finally, the topic group further considered that it was important that the statutory test defining the interface (both inside and outside hospital) should be set down as simply as possible.

Recommendation 3 – stakeholders, including in particular the Royal College of Emergency Medicine, told us of the real problems caused by the lack of clarity as to the legal powers available in A&E to require a person to remain there pending assessment and potential admission to hospital, in particular where the person appeared to be at risk of suicide but was seeking to leave. The topic group considered that there were two options in order to ensure ambiguity as to the legal position did not give rise to the potential for harm to vulnerable individuals. Either option had risks. Extending the current 'holding' powers in s.5 MHA to cover the position of those in A&E would be to extend the coercive powers of the MHA and out of line with the overall direction being taken by the Review (separately, identifying, legally, what constitutes an A&E department is not straightforward). Conversely, solely relying upon the extension to s.4B would risk not covering the group of individuals who appeared not to lack capacity to agree to remain at the hospital, but nonetheless appeared to be at high risk to themselves. The size of this cohort would depend, in part, upon whether guidance could or should be provided in the Code of Practice as to the nature of the factors circumstances required to give rise to the necessary reasonable belief that a person lacked capacity to decide whether to remain in hospital pending assessment. The topic group considered that the choice between the two recommendations was one that more properly fell to the wider working group and Chair/Vice-Chairs to consider as part of the overall direction of the Review's recommendations. The topic group noted that, if reliance were to be placed on s.4B alone, it was likely that s.4B should be amended to make clear (or the Code of Practice expressly confirm) that it covers steps being taken to secure a person's life, as there might otherwise be argument as to whether preventing someone leaving in the circumstances described fell within the definition of taking steps to prevent a serious deterioration in their condition.

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Recommendation 4 – this recommendation was made in the context of a request by the Government as part of its response to the Law Commission Mental Capacity and Deprivation of Liberty report. From the perspective of the Review's remit, the topic group considered that it was important that it should be possible to authorise a deprivation of liberty under the LPS by reference to the risk of harm to others because otherwise it would not be possible (1) to use the LPS in the mental health setting, as per recommendation 2; or (2) to use the LPS to enable a small but significant group of individuals, for instance those with learning disability and paedophilic tendencies, to be discharged from the MHA to reside in the community with a suitable framework around them. The topic group were clear, however, that the LPS should not routinely be used as a tool for public protection, such that authorisations on the basis primarily of risk of harm to others should be referred to an Approved Mental Capacity Professional ('AMCP'), and consideration be given to whether the MHA should be used instead.

Recommendation 5 – this recommendation was made, in part, in the context of a request by the Government as part of its response to the Law Commission Mental Capacity and Deprivation of Liberty report. The topic group identified in its work that seeking to frame the issue solely as to whether fusion was a desirable goal was unduly narrow, not least because 'fusion' itself is a term that has multiple meanings. The topic group therefore prioritised identifying a framework for assessing the potential future direction of travel. It identified that a framework initially drawn up by the Kings Policy Institute⁶⁵ was a useful tool, as it allowed consideration of the relative importance of the place of individual autonomy balanced against legal certainty (the topic group noting in this context, the place of the individual in wider family and social networks, but with the awareness that not all individuals enjoy such networks). The topic group commended this tool to the Review leadership and Government to frame the further work that needs to be done in this context.

4. Implementation of recommendations

Recommendations 1 to 3 will require legislative changes (to the MCA, rather than the MHA). Recommendation 4 may require legislative amendment to the MCA depending upon precisely how the Mental Capacity (Amendment) Bill is enacted. These legislative changes will require the version of the Code of Practice to the MCA in force at the time to be amended. The Code of Practice to the MHA will also need to be amended to ensure that it contains the same guidance.

⁶⁵ King's Policy Institute: *The Future of the Mental Health Act* (May 2018).

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Central government will need to be involved, as will HMCTS for Tribunal Service and Court of Protection and their respective judiciary in respect of parallel authorisation (recommendation 2). These recommendations would directly or indirectly impact upon Wales as well as they will have impacts upon both reserved (justice) and non-reserved (wider health) matters. Insofar as they require changes in practice, it will require action on the part of relevant professional bodies (in particular the Royal College of Psychiatrists) to embed new practices.

The major implementation issue, in terms of both funding and political acceptability, will be the extent to which the recommendation on the interface in hospital leads to a shift in population between those subject to the MHA and those subject to the MCA. The topic group consider it likely that the effect of implementing the recommendation will be that fewer people will be detained under the MHA (but will still be subject to the MCA/LPS, as opposed to being purely informal patients), as the MHA will not in future be available for non-objecting patients. In the case of patients who would otherwise have been detained under s.3 MHA 1983, this means that they would not then be eligible for s.117 aftercare or the perceived safeguards surrounding treatment or access to tribunal (a matter of concern for the topic group in recommending against a major shift in the patient population from s.3 MHA to the LPS). Conversely, they will not have been subject to the stigmatising effect of detention under the MHA; even if the topic group – as with others – was unable to find evidence of the extent to which DoLS is perceived as stigmatising, it is extremely unlikely to be seen as *more* stigmatising, not least because it is so much newer and carries with it much less historical baggage.

The numbers of those who would by implementing recommendation 1 be taken outside the scope of either the MHA or the LPS altogether – ie to be truly informal, even though they lack capacity – is relatively small. Again, though, to the extent that such a person would previously have been subject to s.3 MHA, they would not now be eligible for s.117 aftercare.

It is difficult to address the effect of implementing recommendation 4 because the topic group is endorsing what it understands to be the Government's intention in the Mental Capacity (Amendment) Bill of allowing the LPS to be used in cases of harm to others. It is, however, recommending additional steps – in particular automatic referral to an AMCP – in cases of pure public protection. The Law Commission's impact assessment accompanying its report proceeded on the basis that 25% of all LPS authorisations would require AMCP involvement, but that was across the board, and it did not break down those where it was primarily on risk of harm to others (which was also a trigger for the Law Commission). The number of such cases is, though, likely to be relatively small, because (and this would be reinforced in the Code of Practice to the MCA) the number of cases where it will be appropriate to use the LPS for public protection, as opposed to the MHA, will be relatively small.

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5. Evidence and analysis

Original sources included the submissions provided in response to the call for evidence, Law Commission Mental Capacity and Deprivation of Liberty Report (and accompanying impact assessment), CQC report (January 2018) on the rise in the use of the MHA to detain people in England. The targeted engagement undertaken by the topic group around its emerging thinking on the in-patient interface produced a consensus that the current position in DoLS (which would be maintained in the LPS) was unsatisfactory, but much less agreement as to what should be put in its place, the central divide between those wishing clarity and those wanting flexibility. The service users who took part in a meeting convened to consider the options then on the table broadly expressed a view in favour of discretion, but only where such was accompanied by concomitant duties on the relevant professionals to support the person to participate in the process and to be clear and transparent in the reasons then given for choosing the MHA or the MCA. A significant minority of stakeholders expressed the view that the Review should not be seeking to maintain an interface between the MCA and the MHA, but should rather be seeking to fuse the two pieces of legislation. The topic group did not conduct engagement around the question of the longer-term direction of mental health law in which this issue could be considered, but this will be done in the near future (under the aegis of the Working Group, rather than the topic group).

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The police role

Chair: Matthew Scott, Police and Crime Commissioner for Kent, and National Association of Police and Crime Commissioners lead for mental health.

Working Group Lead: Mark Trewin

Secretariat: Matthew Lees, DHSC

Membership

- Claire André, Mental Health Nurse Police Liaison lead for Northumberland Tyne & Wear Foundation NHS Trust
- Michael Brown, College of Policing
- Mark Collins, Mental Health lead, National Police Chiefs Council
- Kevin Hanner, AMHP lead, Norfolk County Council
- Viral Kantaria, NHS England
- Tom Milsom, Independent Office for Police Conduct
- Linda Robinson, Home Office
- Mary Jane Tacchi, Consultant psychiatrist, Newcastle and North Tyneside Crisis Assessment and Treatment Service.
- Alex Thomson, Central and North West London NHS Foundation Trust
- Marianne West, Service user and carer

Affiliate members - for particular items only:

- Kate Davies, NHS England, for police custody care item only
- Dave Partlow, South Western Ambulance Service, for transportation item only

In addition to the core members, the topic group may bring in expert contributors for specific issues within the topic, or to test emerging findings.

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Terms of reference

Remit

The interim report said the review 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 and Bradley reports
- Equality issues, particularly police interactions with people from BAME communities under the MHA

The group will consider how current inequalities can be addressed in relation to the Mental Health Act, and any recommendations will consider the potential impact upon individuals identifying with protected characteristics under the Equality Act 2010. In particular, the review is seeking to address racial disparities, with a specific emphasis on people of African and Caribbean descent or heritage.

The purpose of this group is to identify potential recommendations the review could make, in relation to the above, and to support the review's overarching goals (see below).

Timing and outputs

i. Review point:

Gap analysis and any additional research requirements by 30 June 2018.

Progress update to the review by 20 July 2018.

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ii. Final report

The group will produce a short report to the review leadership by 14th September 2018, using the agreed format, setting out key findings for consideration by the Review as they prepare their final report and recommendations to government.

The topic group's work will be supplemented by additional engagement activity.

Interdependencies

- Addressing rising rates of detention under the MHA
- The disproportionate number of people from black and minority ethnic groups detained under the Act

Goals set out in the review's interim report

- 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

Report

1. Issue

The most recent amendments to the Mental Health Act were made by the Policing and Crime Act 2017 to update and expand the legislation, and reflect improved practice, around police powers under the Act. Central to this was the need to provide clarity in the Act on the 'exceptional circumstances' under which police custody can be used after a person is detained by police under section 136.

Nevertheless, the Independent Review, in its interim report, identified a number of areas where there remains work to be done in regard to improving the interface between mental health services and policing. In particular, more needs to be achieved to ensure that mental health services are commissioned and resourced adequately to perform their role to a full extent so that the contributions of police officers, and the use of police facilities such as cells and vehicles, are required only where appropriate.

Issues to do with equalities, particularly with how police forces can do more to address how they improve their responses to people from BAME backgrounds who present with mental illness, remains a vital issue, with tragic cases, such as the deaths of Sean Rigg and Olaseni Lewis, a constant reminder of past police failings.

Remit

The remit of the Police Role Topic Group was to help the Review consider further:

- 1. 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?**
- 2. 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.**
- 3. Why police vehicles rather than ambulances are still transporting the majority of people under these sections, and what can be done to address this.**
- 4. 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.**

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5. Equality issues, particularly police interactions with people from BAME communities under the MHA.

The topic group was asked to consider how current inequalities, and the disproportionate impact on particular groups, can be addressed. The purpose of this group is to identify potential recommendations the review could make, in relation to the above, and to support the review's overarching goals.

2. Findings

1. 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?

The Topic Group agreed that police cells should be removed altogether as a place of safety in the Act, and proposed 2023/24 as an achievable target date for this. The Topic Group also recommended:

- A national agreement between mental health services and police on how people detained under s136 should be safely 'handed over' to health services, and the circumstances under which police officers may be required to stay at health settings.
- The Act should specify that the preferred place of safety under s135/s136 is defined as a "health based place of safety" or "s136 suite", as the current definition is too wide and unhelpful.
- Guidance from NHS England, NHS Improvement and the Care Quality Commission should set out the minimum standards for s136 suites, eg the physical environment and staffing requirements, and an audit of current provision against these standards should be undertaken as part of preparations towards removing cells from the Act altogether. This audit should identify where new capital and revenue resources are required
- To support this, the Royal College of Psychiatrists should update its 2013 Position Statement on service provision for s136.

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- A recent study⁶⁶ by the Psychiatric Liaison Accreditation Network based at the Royal College of Psychiatrists' College Centre for Quality Improvement found that less than a quarter of the Emergency Departments in England surveyed had a safe and suitable mental health assessment room. NHS England and NHS Improvement should also undertake an audit of mental health assessment rooms in Emergency Departments to ensure that they are safe and suitable in line with existing guidance from the Royal College of Psychiatrists and the Royal College of Emergency Medicine. Future capital funding that is made available by the government to the NHS should be invested to improve these assessment rooms/spaces where those improvements are needed, supported by NHS England, NHS Improvement and STPs.
- The Government should consider whether there is scope to amend s136 to allow a police officer to end the detention, for example on the advice of health professionals or a senior officer, in cases where it is clear a full Mental Health Act assessment is unnecessary.

2. 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.

The Topic Group agreed that the responsibilities of NHS commissioners under section 140 of the Act must be discharged more consistently and more effectively. Section 140 makes it the responsibility of clinical commissioning groups to ensure that arrangements (ie non-specialist beds) are available to receive patients in cases of special urgency.

- NHS England and the CQC should work with CCGs, LAs, the AMHP Leads Network and providers to understand how s140 is being used on the ground and to issue clear joint guidance [likely NHSE to CCGs/NHS commissioners] to allow NHS commissioners to discharge their statutory duties under this section of the MHA more effectively and consistently.
- NHS England and NHS Improvement should support commissioners and providers to recognise in their capacity and pathway planning that a number of Mental Health Act assessments take place in police custody, a proportion of which result in detention, and to consider how better to recognise and respond to these urgent cases.

⁶⁶ Bolton, J., Palmer, L., & Cawdron, R. (2016). Survey of psychiatric assessment rooms in UK emergency departments. *BJPsych Bulletin*, 40(2), 64-67. doi:10.1192/pb.bp.114.049742

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- This should be informed by better data collection and sharing by LA AMHP services - data on Mental Health Act assessments collected by AMHPs, including sources/settings for assessments, duration and waiting times should be made available and shared routinely with NHS commissioners and providers.

3. 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 Topic Group agreed that the Code of Practice position on transportation is broadly correct, ie that 'hospital or ambulance transport will usually be preferable to police transport, which should only be used exceptionally, such as in cases of extreme urgency or where there is an immediate risk of violence'. The Topic Group *does not recommend removing police transport altogether from the Act, nor does it suggest that the review specifies a proportion of cases in which ambulance transportation must be used.*

- The Topic Group recommends that there should be formal standards for ambulance services' responses to s136 conveyances and all other mental health crisis calls that demonstrate equivalence with the new ambulance response standards for physical health emergencies and reflect the principle of parity of esteem. In advance of changes to the law and Code of Practice regarding conveyance, the relevant national bodies should support ambulance commissioners and providers to improve their s136-related performance. The Code of Practice should be clearer about those cases of extreme urgency or risk of violence in which police transportation may be preferable.
- Ambulance commissioners and ambulance trusts should consider commissioning bespoke mental health vehicles, as part of improvements to the wider ambulance fleet.
- Underpinning this is a fundamental recognition that the demand that s136 places on ambulance services is only a very small proportion of the overall mental health crisis-related demand on ambulance services, and that ambulance services' responses to all mental health crises – as well as to AMHP requests for transport for transport for community non-emergency assessments under the Act – need to improve. We recommend that as part of the Long Term Plan, NHS England invests capital and revenue to improve the ambulance fleet, to create new joined up functions between mental health services, ambulance services and other urgent and emergency care services, and to significantly expand the education and training of the paramedic and wider ambulance workforce in mental health.

A multi-agency group involving the Association of Ambulance Chief Executives, NHS England, NHS Clinical Commissioners National Ambulance Commissioners Network, the College of Paramedics, the College of Policing and the National Police Chiefs' Council has recently been established. We welcome the establishment of this group and feel that it is ideally placed to take forward these recommendations.

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4. 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

The Topic Group *did not agree* that the Review needs to make this recommendation again. This is because work is already underway, with Home Office and NHS England working to respond to the recommendation made by Dame Elish Angiolini. The Group also felt that the matter was out of scope of the Review as did not concern the Act or mental health services directly.

5. Equality issues, particularly police interactions with people from BAME communities under the MHA

The Topic Group considered the fact that BAME people are, if anything, underrepresented in s136 statistics, which raises the possibility that police may more often decide to use the criminal justice route for people from these backgrounds. The Topic Group agrees therefore that all of its recommendations should be tested with MHARAC to consider further whether there may be any adverse impact. In addition, the Topic Group agrees:

- The patient care race equality standard (PCRES) being developed by MHARAC should apply to police forces. The Crisp Commission (2016) made a recommendation to identify a clear and measurable set of Race Equality Standards for acute mental health services – the PCRES. This organisational competency framework will help police forces identify what is required, will also apply to local authorities and the NHS, and will hold local systems to account more robustly to improve overall outcomes for black people and other minority ethnicities.
- The College of Policing should also update its Equality Improvement Model to include a greater focus on mental health and BAME issues for police forces to demonstrate progress against equality objectives.
- A police/mental health Independent Advisory Group (or other appropriate approach) should be set up in each police force area.
- Additional data and research is essential to find out what is happening to people from different backgrounds and how they experience interactions with the police while ill. This must include qualitative studies, and service user involvement is crucial. Some of the evidence required will come from MHARAC.

There is already excellent work underway, and the Topic Group has obtained numerous case studies and examples from police forces.

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The Topic Group considered its recommendations in light of other protected characteristics, and given the demographic data in the Mental Health Act statistics shows a fairly even split in terms of gender and through age groups, it agreed that there is no reason to suppose its recommendations will have adverse impacts, but that care should be taken by Government in implementation to undertake full impact assessments, in particular as improved data emerges. For example, PCRES will help provide a feedback mechanism for this.

6. Additional recommendations

Members of the Topic Group undertook to continue to consider two additional issues:

- The lack of police emergency powers to remove people from private premises
- Whether the Code of Practice should be amended to state that a severely intoxicated person may be detained under s136 but only under very specific circumstances, and only where a mental disorder is evident.

3. Rationale

1. 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?

The Topic Group considered the use of police custody for s136 in 2017/18. This year comprised 5 months (i.e. from January 2018) of the more stringent requirements of what constitutes 'exceptional circumstances' for the use of police custody, as introduced by the Policing and Crime Act 2017; and 7 months of the old arrangements. The headline figure for England was 380 cases, a reduction from 912 in 2016/17, almost an eradication of the 8,600 cases in 2011-12, when formal collections began.

Of these 380 cases, 160 were from one police force area - Sussex Police. There were fewer forces reporting zero cases this year than previously. We hope soon to see a breakdown over time that shows the effect of the January 2018 changes. But the group was in agreement that i) removing cells is the right thing to do for patients, to reduce the element of people feeling criminalised, and to make sure that people receive medical assessments and care in the right place at the right time, and ii) the low numbers remaining in the 2017/18 statistics represent failings in the system and not people who are too dangerous for psychiatric hospitals to manage.

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Nevertheless, there is still work to be done to ensure that the commissioning and provision of health based places of safety is sufficient nationally. Establishing national commissioning standards, and auditing against these will be necessary to ensure that the right services are in place everywhere.

2. 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.

The Topic Group felt that s140 was central to solving the issue and that the law itself was broadly adequate, with the responsibilities of NHS commissioners under section 140 of the Act needing to be discharged more consistently and more effectively.

3. 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 Topic Group did not recommend removing police transport altogether from the Act, nor did it suggest that the review specifies a proportion of cases in which ambulance transportation must be used, as this would be purely arbitrary. NHS England and Home Office analysis looked in detail at the reasons why police officers do not always call an ambulance, and certainly found that some ambulance trusts are doing better than others. There are many reasons why police vehicles are used, of course often ambulances are not requested because the perception is they take too long, and the more police vehicles are used, the longer ambulance service takes to respond – which seems a simple correlation, but the picture is more complex when you look at individual reasons.

But there are wider conversations about gearing up ambulance services to handle crisis services more widely. In particular, the need to consider vehicles and staff – work is underway to get more information from ambulance trusts to see what specialist crisis vehicle would be needed, how many and at what cost.

4. 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

The Topic Group considered this matter to be out of the scope of the review of the MHA. Removing police custody as a place of safety under the Act would then weaken the argument for improving the health provision in police custody for the purpose of improved responses to people detained under s136. This does not mean that there are other supporting arguments, such as later in the CLS pathway. There was also a concern from the PCC and Home Office representatives that there were already too many commissioners in police custody.

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5. Equality issues, particularly police interactions with people from BAME communities under the MHA

Rationale is discussed above.

4. Implementation of recommendations

1. 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?

This would require a change to the Mental Health Act, to remove police cells as a place of safety, we also propose amending the definition of place of safety to make the primary place a Health Based Place of Safety or s136 suite.

A handover protocol would need to be finalised and agreed by relevant national bodies – primarily RC Psych, National Police Leads Council, the Association of Police and Crime Commissioners and ADASS.

Revisions to the MHA Code of Practice would also be required.

2. 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

This would require joint guidance and better data.

3. Why police vehicles rather than ambulances are still transporting the majority of people under these sections, and what can be done to address this

This would require the Association of Ambulance Chief Executives and the College of Paramedics to accept the proposal to make mental health emergencies a formal category 2 emergency.

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4. Equality issues, particularly police interactions with people from BAME communities under the MHA

The Topic Group's recommendations are primarily to do with guidance, work which will fall to the College of Policing. There will also be a role for Home Office, APCC and the Police Chiefs' Council in setting up Independent Advisory Groups (or other appropriate approach) in force areas.

Interdependencies with PCRES and MHARAC are vitally important for this work, and for all the Topic Group recommendations.

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Criminal justice system

Chair: Carolyn Kirby OBE - President, Mental Health Review Tribunal for Wales

Working Group Lead: Shubulade Smith, Consultant Psychiatrist

Secretariat: Sarah Palmer, DHSC

Membership

- Graham Durcan (criminal justice system researcher)
- Tim Exworthy (forensic psychiatrist)
- Tam Gill (Chair, Mental Health Lawyers Association)
- Nick Hunter (service user consultant)
- Tony Lingiah (mental health practitioner)
- Dr Sarah Markham (Visiting Researcher King's College, London)

In addition to the core membership, the topic group may bring in expert contributors for specific issues within the topic, or to test emerging findings, including:

Statutory health (DHSC/NHS England) and justice (MOJ/HMPPS/HMCTS) bodies to join for appropriate meetings in an observer role

Individuals with direct service insight will be invited to relevant discussions (eg judge or court representative, prison staff)

There are further experts and practitioners in this area who will be invited to feed directly into the topic group's work and/or join to provide evidence and ideas in relevant meetings

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Terms of reference

Remit

The interim report said the review will consider further:

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 transferred prisoners serving life or other indeterminate sentences

The restricted patients system

- 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

Criminal courts and Tribunals powers and processes

- 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

This group will also look jointly with the procedural safeguards group at tribunal issues relating to restricted patients, and will formally own tribunal issues for restricted patients in terms of reporting.

The topic group will consider how current inequalities can be addressed in relation to the Mental Health Act, and any recommendations will consider the potential impact upon individuals identifying with protected characteristics under the Equality Act 2010. In particular, the review is seeking to address racial disparities, with a specific emphasis on people of African and Caribbean descent or heritage.

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The purpose of this group is to identify potential recommendations the review could make in relation to the above, and to support the review's overarching goals (see below).

Timing and outputs

i. Review point:

Gap analysis and any additional research requirements by 31st May.

Progress update to the review by 20th July 2018.

ii. Final report

The group will produce a short report to the review leadership by [21st] September 2018, using the agreed format, setting out key findings for consideration by the Review as they prepare their final report and recommendations to government.

The topic group's work will be supplemented by additional engagement activity. Strong engagement with Welsh interested parties will be important since justice policy is not devolved and so recommendations made to the UK government will impact Wales.

Interdependencies

This topic group will need to connect and share information as appropriate to the following other topic groups:

- Tribunal, hospital manager and renewals - there are a set of distinct issues around offender patients and Tribunals which will be covered at a joint session between these two topic groups
- Discharge, care planning and aftercare – needs special consideration of issues for offenders / immigration detainees
- Mental Capacity Act interface – if any of the changes here should impact Tribunals

Goals set out in the review's interim report

- 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

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- 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

Report

1. Issue

People with mental health problems involved in the criminal justice system (CJS) should have equivalence (Availability, Accessibility, Acceptability and Quality) in terms of access to mental health care, outcomes, rights and safeguards with civil patients, whilst being mindful of the need to protect the public from further offending. But that is not the case: defendants appearing before the criminal courts; prisoners, and offenders in secure hospitals are all subject to delays in getting the mental health care they need.

We have heard that it takes on average 100 days to transfer from prison to hospital, and during that time the prisoner's health is likely to be deteriorating. We have also heard that, once in hospital, patients are subject to further delays to move forwards towards recovery, for instance in getting approval to go on leave, to transfer to a lower level of security, or for some patients subject to certain sentences, in getting discharged after they no longer need in-patient treatment.

Many people charged with a criminal offence require mental health treatment and should have been diverted to hospital, but instead remain in prison and do not receive the care they need. Concerns have been raised that prison may even have been used as a "Place of Safety". Underpinning this is that the number of defendants remanded to hospital has been dropping, whilst the numbers of prisoners transferred to hospital whilst on remand is growing.

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Black, Asian and Minority Ethnic (BAME) people are heavily over-represented in prison populations, the CJS and in secure care. We are mindful that any recommendations that improve access to, outcomes and quality of mental healthcare will particularly impact favourably on BAME people in contact with the CJS.

This topic group has looked at four distinct areas of the CJS with a view to ensuring equivalence of access to treatment, and unblocking delays:

- The powers that criminal courts have when dealing with a defendant under the Mental Health Act, in particular, their choices over remand to prison or remand to hospital for treatment;
- Transfers between prisons and secure hospitals;
- The role of the Justice Secretary in managing 'restricted' patients; and
- The role of the Parole Board.

2. Findings

Criminal Court Powers

Recommendation 1 - Magistrates' courts should have the following powers, to bring them in line with Crown Courts:

- remand for assessment without conviction under S35 of the Mental Health Act (MHA)
- remand for assessment and treatment under S36 of the MHA
- the power to commit a case to the Crown Court for consideration of a restriction order following an 'actus reus' finding
- the power to hand down a supervision order following an 'actus reus' finding (where a person is not fit to enter a plea, but has been found to have committed the offence) under S1a of the Criminal Procedure (Insanity) Act 1964.

Recommendation 2 – to reduce the use of prison remand through:

- amending Schedule 1, S3(6) of the Bail Act which allows remand to prison for a defendant's own protection or, if he is a child or young person, for his own welfare or in his own interests
- Introducing explicit exemption in MHA that prison is not to be used as place of safety

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Prison transfers

Recommendation 3 – to improve the process for transfers between prisons and hospitals by:

- Creating a new Approved Mental Health Practitioner (AMHP) equivalent role for part III and in particular for transfers from prisons (and immigration detention centres)
- Introducing two sequential statutory time limits of 14 days: between notification of a need for an MHA assessment and that assessment taking place, and between that assessment and the effect of transfer (a total time limit of 28 days)
- Ensuring the CQC monitors hospitals' compliance with these timescales

Powers held by the Justice Secretary

Recommendation 4 – to reduce delays for restricted patients and support swifter moves towards recovery and discharge, through:

- MoJ Mental Health Casework Section (MHCS) allocation of restricted patients⁶⁷ in to categories that reflect the complexities of the case, and reviewed over time, and for decision making to be delegated to the responsible clinician;
- expanding the powers of the mental health Tribunal so that they provide an additional avenue for directing leave and transfer during an application for discharge;
- expanding the powers of the mental health Tribunal so that they can remove a S41 restriction order for a continuing hospital order;
- introducing a statutory review of conditional discharge by the Tribunal;
- recording, in the Care and Treatment Plan, what should happen what factors should be taken into account when readmission is being considered after a conditional discharge (concerning use of informal admission, S2 and recall);
- requiring the supervising psychiatrist to consult with the social supervisor when considering recalling the patient. The social supervisor should seek the patient's views and consider any evidence they want to present; and

⁶⁷ Current and new

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- requiring the MHCS to consider the patient's views and any evidence they present.

Recommendation 5 – there should be a common framework for assessment of risk across criminal courts, clinicians and the Justice Secretary. The assessment needs to be regularly reviewed (at least annually and before every Tribunal hearing). Every patient should have written in to the Care and Treatment Plan what their risk levels are.

We believe that all of our recommendations, if taken on board, will help to address current imbalances, and improve care, support and outcomes, for BAME patients. We would also like to ensure that any recommendations concerning advocacy are included for part III patients, and for prisoners awaiting transfer.

3. Rationale

Criminal Court Powers

We heard from members of the judiciary that their powers are limited when dealing with defendants in the magistrates' court. This is despite the fact that magistrates will see all defendants for their first hearing (including those that are later sent to the Crown Court) and will dispose of more than 90% of criminal cases. We believe that the courts should be able to address mental health issues at the earliest opportunity, and that means giving magistrates' courts the power to seek assessments and treatment from the first hearing onwards.

The original policy rationale for restricting their powers is not clear, but directing any person to hospital for detention and treatment under the MHA is a decision that needs to be taken with extensive consideration, and it may be that this was considered to be best placed with the expertise of the Crown Court. However, magistrates' courts *are* able to order detention and treatment via a hospital order (provided the offence is one that could have received a sentence of imprisonment), and it is not clear why they can be entrusted with this power and not others. It is recognised that additional training will be required for magistrates to ensure they fully understand their powers and duties in this regard.

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Remands for assessment and treatment

The MHA allows for two types of remand to hospital, remand for assessment; and remand for assessment and treatment. The Crown Court can use both of these powers without limitation. The magistrates' court cannot remand for assessment together with treatment, and it can only remand for an assessment following a conviction. This means that for any defendant who has not been convicted (either because they have not yet entered a plea, because they will be sent to the Crown Court for trial or because they are unfit to enter a plea) , their only option is to release them on bail, where they may not be accessing the treatment they need, or to remand them in prison where, if their condition is serious enough, they will await potential transfer to hospital (which in itself is fraught with problems and delays – see below). We heard how an audit carried out on a single snapshot day found that 50% of prisoners being assessed for transfer to hospital were there on remand (ie unsentenced)⁶⁸. We are recommending that the magistrates' court have the same powers to remand to hospital, before conviction, as the Crown Court.

Remittal to the Crown Court for a Restriction Order

Although the magistrates' court can make a hospital order (and order for indefinite detention and treatment) they cannot impose a 'restriction' order which means that some future decisions need to have agreement from the Justice Secretary. The restriction order is made to protect the public, and since it carries severe future restrictions on liberty, we think it is right that this power sits only with the Crown Court. The magistrates' court is able to remit an offender for whom they have issued a hospital order, to the Crown Court for them to consider imposing a restriction order. However, they can only do this if the patient has been convicted, which means they cannot send the case to the Crown Court if the patient has been given the hospital order following an 'actus reus' finding. This means that some patients, who could pose a risk to the public, cannot be considered at all for a restriction order. We recommend that the magistrates' court is able to remit any hospital order case to the Crown Court, who will exercise their proper judgement in considering whether a restriction order is justified.

⁶⁸ <https://s3.eu-west-2.amazonaws.com/nhsbn-static/Other/2018/Data%20Transfers%20and%20Remissions%20Census%20Report.pdf>

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Supervision orders

A Supervision order requires an offender to be treated as an outpatient. Similar to that above, the magistrates' court cannot impose a supervision order following an 'actus reus' finding. This means that their only options are either to issue a hospital order, which could be an unwarranted restriction of liberty if the patient could be treated in the community, or an absolute discharge, which does not include any requirements at all, and is not suitable for most cases. Given that magistrates' courts can be entrusted with the power to order detention via a hospital order, this seems to be nonsensical. Magistrates should be empowered to impose supervision orders with a condition of psychiatric treatment following an 'actus reus' finding.

S45A

The 'hybrid' order imposes a sentence of imprisonment but directs that the sentence is served in a hospital initially until the person is sufficiently stable to return to prison. We heard from submissions to the review that some stakeholders feel S45A should be repealed. We heard that the Sentencing Council are developing new guidelines on mental health which should assist the courts with respect to S45A. The Royal College of Psychiatrists may also wish to issue guidance concerning making S45A recommendations to court. We were satisfied that this power is used infrequently, and the small number to whom this does apply should benefit from the new guidelines.

Reducing the use of prison for remand

The use of remand to hospital for assessment (S35 MHA) has been reducing, and the numbers of remand prisoners being transferred to hospital has been growing. We have heard that problems accessing treatment in the community, or finding available beds for remand to hospital, means that, in some cases, remand in prison is considered better than release on bail, especially where there is an immediate risk of suicide. We heard that on a number of occasions people were being remanded to prison, despite court NHS Liaison and Diversion services identifying that the person needs admission, because a bed could not be found in time.

We believe that this should never be the case, and are recommending amending the Bail Act to make it clear that prison cannot be used, for the defendant's own protection (or if he/she is a child or young person, for his/her own welfare or in his/her own interests) where that is in order to provide a route in to in-prison mental healthcare because of lack of access in the community. We are also recommending that the MHA explicitly states that prison cannot be used 'as a place of safety' whilst a hospital bed is found.

Prison transfers

Although there is a principle of equivalence of care with people in the community, there are several differences between the processes for admission from the community and from prison. In particular there are no statutory time limits for assessment or admission; there is no AMHP or equivalent independent role to manage the assessment and admission process; and there is no agreed definition (between prisons and hospitals) of what constitutes an urgent need to transfer. Although there is a time limit for transfer of 14 days, only 34% of prisoners were transferred within this timeframe in 2016-17, and 7% (76 people) waited for more than 140 days⁶⁹.

We heard from NHS England and Her Majesty's Prisons and Probation Service that there are considerable delays and perverse incentives in the current system for transferring prisoners to secure hospitals. This included an average wait time of 100 days, and delays waiting for the first assessment (an average of 32 days) and between the first and second assessment (an average of 34 days)⁷⁰. We believe that a lack of clarity over when the clock starts gives staff the opportunity to manipulate the timeframe for processes like assessments. It was suggested to us that the delay for the second assessment (and potentially the first assessment also) was because clinicians were waiting for a bed to become available first. Also, psychiatrists find it difficult to carry out assessments in prison (getting access to the prisoner).

We believe that by giving prisoner's rights that are closer to those of civil patients, we can make transfers much more effective. We are recommending that AMHPs are given the role of managing applications for admission, acting independently of both prison and hospital staff. In addition to this, we want to introduce some statutory time limits to prevent delay, to help the AMHP unblock the system in both prisons and hospitals. Compliance with these time limits for each hospital should be overseen by the CQC.

In addition to providing impetus to the transfer, there would be a number of other benefits to the AMHP role, in particular with respect to upholding the rights of the individual. Although it is not for us to specify, we think it would be helpful if this role were to be commissioned by the local authority in which the prison is based⁷¹. This would enable better links to housing and social care provision upon release. The AMHP may also be better placed to consider the social justice and cultural needs of the prisoner. The latter is

⁶⁹ Mental health in Prisons, Report by the Comptroller and Auditor General, Ordered by the House of Commons to be printed on 28 June 2017, 26 June 2017

⁷⁰ <https://s3.eu-west-2.amazonaws.com/nhsbn-static/Other/2018/Data%20Transfers%20and%20Remissions%20Census%20Report.pdf>

⁷¹ Both the Care Act and the Social Services Wellbeing (Wales) Act place social care responsibility on the local authority in which the prison is based

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particularly important for black people, who are disproportionately represented amongst the prison and forensic inpatient population.

Powers held by the Justice Secretary

RCs must apply to the Ministry of Justice Mental Health Casework Service (MHCS) when they want to allow the patient leave (of any kind, from escorted leave within the grounds of the hospital, to unescorted leave in the community), or to transfer the patient to another hospital. We heard from numerous sources that this causes considerable delays (we heard from one patient who waited 150 days for a decision). We heard of cases where the delay was as long as a month for transfer to a hospital with the same level of security.

We heard from MHCS that there had been a recent increase in the time taken for decisions to be made, that related to a sudden drop in staff numbers which created a very large backlog. We have accepted that this was unavoidable, and that the decision making time has since reduced. However, we also believe that the current time taken for decisions is still too long adding to length of stay and this disadvantages patients under restriction orders compared with those who are not restricted or under civil sections. Again, this has a disproportionate effect on black people who are more likely than their white counterparts to be detained under Part III of the MHA.

We heard from MHCS and from clinicians that the delay is not just down to staff within the MHCS. It takes around 4 hours for a complex decision to be made on an application, however, that process can only start once the caseworker has all of the relevant information. It often takes time to obtain this from hospitals, or to get confirmation from a receiving hospital that they are willing to take the transfer. For this reason, we are recommending that the RC should be able to take some of the less complex decisions, and to simply notify the MHCS of this intention. The MHCS should have 14 days to raise an objection, so ultimately they retain control of the decision.

Delegation to responsible clinicians

To facilitate this we are recommending that MHCS allocates each patient into a category reflecting the level of complexity surrounding the decisions to be made. So for example, for a relatively low risk offender, they may have no objections to decisions concerning leave, but may want to object to any transfer to a hospital that is close to where the victim lives. Oversight of this case would be light touch. It would be for MoJ to determine what categories are suitable, and of which decisions / cases they want to retain complete control. MHCS will be assisted in the allocation process by the introduction of the Care and Treatment Plan that is being recommended as part of detention criteria.

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We also heard suggestions that these powers could be better held independently from government or at least from the Ministry of Justice, in order to mitigate against unnecessary risk aversion. We did consider setting up a new independent body, transferring the power to the Health Secretary, or allowing the patient to apply to the Tribunal for their leave and transfer decisions. We are not persuaded that any of these would reduce the delays or increase the number of applications granted. The data we saw showed that in fact, the MHCS agreed the vast majority of all applications it receives. For last year they agreed with 97% of applications to move down a level of security. We also heard that it can take 12 – 16 weeks wait for a S41 Tribunal hearing.

Expanding the powers of the Tribunal

We do think that Tribunals should be able to consider whether they wish to direct leave or transfer to a lower level of security, when considering an application for discharge. In this way, if they do not feel a discharge is warranted, they may be able to direct that a patient is tried out on leave before their next application. We also believe that the Tribunal should be able to remove a S41 restriction where either circumstances have changed, or more is known about the patient, and the currently assessed level of risk is different to that made by the sentencing court. The S37 hospital order may continue, or the patient could be considered for a Community Treatment Order where appropriate.

Introducing a Statutory Review of conditional discharge

We heard that there are some restricted patients who are conditionally discharged in the community, and for whom a conditional discharge is no longer likely to be appropriate. Although patients can apply to the Tribunal to be absolutely discharged, there are people who are unaware of this, or who lack capacity to make the application. We are recommending that there is a statutory requirement to review the continuation of a conditional discharge after a set period (perhaps every 3 or 5 years). We suggest that this should be analogous to any recommendation for a mandatory review Community Treatment Orders.

Recall

We heard that some patients may be being recalled when it may not be necessary, for example a recall following a civil admission under Section 2 simply because of the fact the patient was still detained after 72 hours. There may be a conflation of a deterioration of mental health with an increase in risk of offending, where this may not in fact be the case. We are suggesting that the Care and Treatment plan, from the outset, should consider the risk that the patient poses, and should set out what should happen if the patient needs to be readmitted. This should cover all options including informal admission, use of a S2 or a S3, or recall. It should specify under which scenarios a recall would be justified (has been refusing to take his medication, has a history of relapsing swiftly when unmedicated and

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becoming violent against others when unwell and is showing signs of relapse). The processes for determining the risk should mirror the MHCS process for categorisation as set out earlier in this report, and should be regularly reviewed.

We also heard that there is no requirement for the patient to understand their responsible clinician is considering recall, so there is no opportunity for them to present their views or to seek input from someone who may be able to vouch for them. We are suggesting that the supervising psychiatrist should consult the social supervisor, and that the supervisor should seek the views of the patient. The patient's views and any evidence they want to present should then be recorded in the recall decision. MHCS should also be required to take the patient's views into consideration, and to record that they have done so. This needs to show that they have taken steps to include the patient in the decision, and if they were unable to do so, must state why not with evidence to support this.

Release via the Parole Board

We heard that there can be delays of many months, and sometimes years, between a Tribunal recommending discharging a patient and release via the Parole Board. We considered a number of possible responses to this, including giving the Tribunal the power to sit as the Parole Board (including appointing members of the Tribunal to the Parole Board to facilitate this), or convening back to back hearings. We don't think this is practicable for a number of reasons, but chiefly because delay is caused by the complication of the Offender Manager's report carried out by probation. It would not be possible to have this report compiled for every Tribunal hearing, on the very small possibility that a discharge may be recommended (the numbers are small – around 10%). So the delays would be likely to continue to exist, with the effect that the Tribunal would have to adjourn while this information is sought. We do however believe that the delays are unacceptable. The Ministry of Justice has informed us that they are doing work to reduce these delays, which will be presented to the Review in October. We suggest that, if the review do not think the proposals put forward by the Ministry of Justice at that point go far enough, this issue is looked at again.

4. Implementation of recommendations

Recommendation 1 - Magistrates' courts should have the same powers as the Crown Courts. This will require changes to primary legislation in the MHA and to the Criminal Procedure (Insanity) Act. The magistracy will require training on their new powers (Judicial College) as will court staff (HMCTS). Any potential increase in use of S35 and S36 may require additional resource in the secure hospital estate. This could be offset by savings to the prison estate, but these savings may not be cashable or transferrable.

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Recommendation 2 – to reduce the use of prison remand. This will require primary legislation to change the Bail Act (MoJ) and the MHA. As above there is likely to be increased pressure on the availability of beds in the secure hospital estate.

Recommendation 3 – to improve the process for transfers between prisons and hospitals. This will require changes to primary legislation to introduce the new AMHP role for Part III, and for the new statutory time limits. It will require funding of additional AMHPs and their training in the CJS context.

Recommendation 4 – to reduce delays for restricted patients and support swifter moves towards recovery and discharge. This will require a change in primary legislation in the MHA to expand the Tribunal powers, and the review of conditional discharge, together with training for the judiciary (judicial college). Legal aid may need to be extended to cover the expanded remit. Additional resources may be needed to support longer Tribunal hearings, but there should be no additional hearings.

The new allocation process for MHCS cases will require development of a framework and processes by MoJ with the help of DHSC policy. This is linked to, but not dependent upon, the introduction of the Care and Treatment Plan as part of civil and criminal detention criteria.

Recommendation 5 – there should be a common framework for assessment of risk across criminal courts, clinicians and the Justice Secretary. This will require development of the framework across MoJ and DHSC, and implementation via a practice direction from HMCTS re what the courts are looking for in terms of risk assessment, training of the judiciary (judicial college), the MHCS (HMPPS) and clinicians (RCPsych)

5. Evidence and analysis

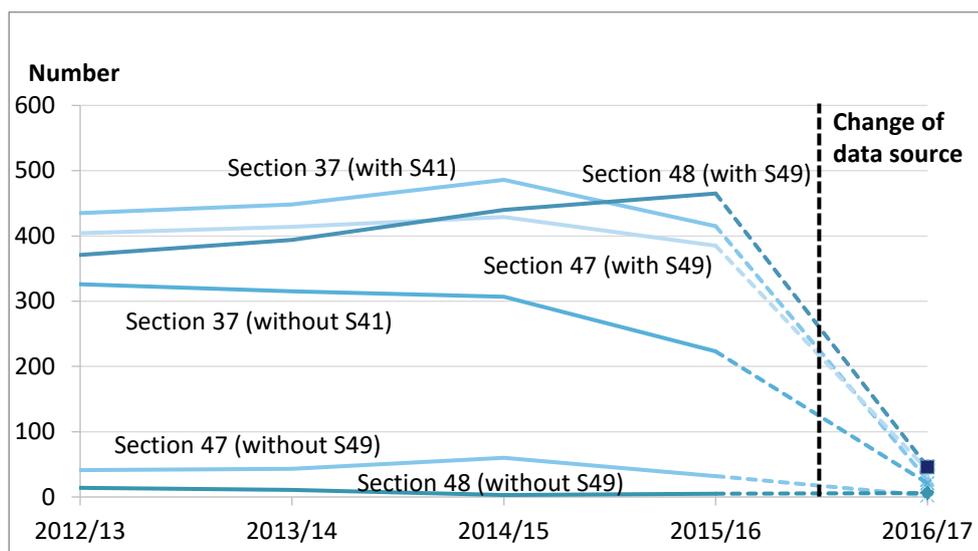
- The use of Section 48 has continued to increase between 2012/13 and 2015/16, 465 cases of Section 48 with Section 49 restrictions were recorded, an increase of 6% (25) compared with 2014/15⁷².
- There are very few uses of Section 48 without Section 49 restrictions. This has increased from 3 in 2014/15 to 5 in 2015/16, however this is fewer than recorded in both 2012/13 and 2013/14, 14 and 11 respectively. (see footnote 72).

⁷² NHS Digital, Inpatients Formally Detained in Hospital under the Mental Health Act 1983 - England, 2012/13 to 2015/16

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- Use of all other sections has fallen, the biggest percentage decrease was for use of Section 37 without Section 41, a fall of 27% (84) between 2014/15 and 2015/16. (see footnote 72)
- The fall in the use of hospital orders in 2016/17 is unreliable due to the known undercount during this period⁷³.
- The fact that more prisoners are being treated in hospital (Section 48/49) could be because they may not have a significant mental disorder when they enter prison and become ill whilst in prison, or there may simply be more prisoners⁷⁴.
- The overall rise in detentions should be seen in the context of a continuing reduction in the number of people spending time in hospital (as shown in the Mental Health Bulletin). Suggesting people who spend time in hospital are becoming more likely to experience detention or repeat detentions as part of their hospital care. (see footnote 74)

Use of Part III sections of the Mental Health Act, 2012/13 to 2016/17



⁷³ NHS Digital (10 October 2017) Mental Health Act Statistics, Annual Figures: 2016-17, Experimental statistics.

⁷⁴ NHS Digital (30 November 2016) Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Uses of the Mental Health Act: Annual Statistics, 2015/16.

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Principles underpinning the Act

Chair: Genevra Richardson

Working Group Lead: Kim Forrester, CQC

Secretariat: Katy Lindfield, DHSC

Membership

- Neil Allen, Solicitor
- Deborah Cohen, AMHP
- Will Johnstone, Rethink Mental Illness
- Carole Murray, Service User
- Dr Kapila Sachdev, Royal College of Psychiatrists
- Julian Sheather, British Medical Association
- Kerry Smith, CQC
- Service User, Carer, NHS SLaM Service User Governor

In addition to the core members, the topic group may bring in expert contributors for specific issues within the topic, or to test emerging findings.

Terms of reference

Remit

The interim report said the review will consider further:

- The possibility and impact of introducing guiding principles onto the MHA itself, in particular considering the principles currently in the Code of Practice

The group will consider how current inequalities can be addressed in relation to the Mental Health Act, and any recommendations will consider the potential impact upon individuals identifying with protected characteristics under the Equality Act 2010. In particular, the review is seeking to address racial disparities, with a specific emphasis on people of African and Caribbean descent or heritage.

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The purpose of this group is to identify potential recommendations the review could make, in relation to the above and to support the review's overarching goals (see below).

A key task of this group will be to explore the considering submissions to the call for evidence, the current Code of Practice principles and how successful they have been, and how the legislation might be meaningfully improved. This leads to how any legislative principles could be enforceable and have impact.

The group will consider what the principles need to achieve and begin to set the direction of what the principles may be to ensure they are meaningful, memorable, and significant for service users, carers and families, and professionals.

Timing and outputs

The topic group will produce a short report, using the outputs template.

There will be four, half day meetings between June and August.

i. Review point:

Gap analysis and any additional research requirements by May 2018.

Progress update to the review by 31st July 2018.

ii. Final report

The group will to produce a short report to the review leadership by 14th September 2018, using the agreed format, setting out key findings for consideration by the Review as they prepare their final report and recommendations to government.

The topic group's work will be supplemented by additional engagement activity.

Interdependencies

- Maximising patient autonomy
- Patient dignity and safety
- Mental Health Act African and Caribbean Group
- Advocacy
- Family and carer involvement

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Goals set out in the review's interim report

- 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

Report

1. ISSUE

Overview of the topic:

The interim report of the independent review said that '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.' The topic group has undertaken work and engagement to consider the case for including principles on the Act and the form these principles should take.

Putting the principles on the face of the Act is likely to make them more prominent and raise awareness of them amongst not only professionals but also services users and their families. This should ensure that they are considered by commissioners, providers, and professionals and should lead to better experiences for service users.

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2. FINDINGS

A. Should Principles be on the face of the Act?

The group concluded that principles should be included on the face of the Act. This should:

- Assist patients, professionals, and those with other caring responsibilities to better understand the key considerations that aim to improve the care pathway for those subject to the Act.
- Provide greater force for the principles by making them a requirement in law rather than mere guidance in the Code of Practice, which practitioners shall have regard to, but from which they can depart.
- This in turn will permit greater enforcement and regulatory action by the CQC, which should itself raise standards
- Ensure that the principles apply to all decisions made, and care received, under the Act and to everyone acting under the Act, including those commissioning and providing services, so as to improve patient experience and outcomes.
- Address issues of low awareness of the principles in the Code of Practice among commissioners, providers, practitioners and service users.
- Bring the Mental Health Act better into line with developing European and international legal norms and expectations.

The group did consider in particular the arguments that (a) placing principles on the face of the Act would prevent them from being easily updated, and (b) the entire Act would need to be compatible with the statutory principles. As to the former, the group concluded that if the principles in the Act were expressed clearly but in sufficiently broad terms they would be unlikely to require frequent modification. The Code can be used to update interpretation as thinking develops. As to the latter, the draft principles have been crafted in such a way as to best ensure that the Act is compatible with them.

B. What should the principles look like?

The group looked at options for possible principles. It considered the principles in the current Mental Health Act Code of Practice, comparable principles in other domestic and Commonwealth jurisdictions, the optimum number of principles, how they should be framed in law and whether the Act should have a purpose clause.

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The group concluded that it was not appropriate to simply transpose the current principles in the Code of Practice on to the face of an amended or new Act. Those principles are lengthy, complex, conflict with each other and there is evidence that they are not well understood in practice and therefore are not effectively or well implemented.

The group recommends that the Act is given a purpose clause and that 4 principles should appear at the beginning of the Act covering (i) empowerment and involvement (ii) therapeutic benefit, (iii) individuality, diversity and equality and (iv) personal autonomy.

The proposed principles

To assist the Review, the group has crafted the following draft new sections of the Act:

Section A1

(1) The purpose of this Act is to enable patients subject to its powers to flourish and fulfil their full potential, having regard to their safety and the safety of others.

(2) In exercising a function under this Act, a person must have regard to the following principles –

(a) *Empowerment and involvement.* All practicable steps must be taken to: (i) ascertain and have special regard to the patient's past and present wishes and feelings, even where an intervention in the absence of consent is expressly permitted by this Act; and (ii) promote and respect the dignity of the patient [and their social relationships.]

(b) *Therapeutic benefit.* Mental health care must be aimed at meeting the patient's needs in a timely manner within a supportive, healing and therapeutic environment, promoting the patient's well-being, and where appropriate helping to identify and resolve the cause of their distress or difficulty, so as to enable the patient to enjoy the highest attainable standard of health.

(c) *Individuality, diversity and equality.* Mental health care must be provided and commissioned in a manner that respects the patient's qualities, abilities and diversity including, in particular, diversity of religious persuasion, racial origin, cultural and linguistic background, membership of any ethnic group, age, sex and sexual orientation.

(d) *Personal autonomy.* Any restriction on the patient's rights and freedom of action shall be done in the least restrictive and least invasive manner necessary to achieve the purpose of this Act.

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Issues raised

There were strong contrasting views within the group about the inclusion of reference to social relationships in the principles. The arguments for inclusion related to the importance of patients being able to maintain a family life and being able to have continued relationships with those close to them whilst detained. The arguments against were that not all patients would have social relationships or that these might be complex or damaging and therefore the principle would not apply universally. There were also strongly expressed concerns that its inclusion in the principles could have a deleterious effect on patients and that to avoid this there would need to be extensive caveats and explanations that would not be appropriate for inclusion in the principles. These are issues which the review will want to consider in making its recommendations on principles.

Other potential concerns considered included:

- That the principles should bring a more holistic approach to 'care', rather than an undue focus on 'treatment' in the form of medication.
- That the principles focused appropriately on identifying and meeting the patient's needs and the causes of their distress.
- That the focus on the individual was not lost in the equality and diversity principle and the potential for tensions between the individual and the group.
- The need to ensure that care under the Act took account of physical as well as mental health.
- The balance of ensuring that patients were dealt with in a timely manner against the risk that putting this in the principles would result in patient assessment and care and treatment being rushed.
- Whether the order of the principles was likely to have a significant impact on their importance and that if so consideration should be given to the order.
- Discrimination in relation to diagnosis and whether this should be included in the principles or in the Code of Practice.

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Necessary legal advice

A number of legal questions were identified by the group, for which the Review might be assisted by legal advice. These include:

- Though we do not foresee any direct conflict between our purpose clause and the existing provisions of the Act we have not been able to conduct a thorough review and further consideration may need to be given to this.
- Whether it is possible to include requirements relating to commissioning in the Act and which services provided under the Act this would impact upon.
- Whether the phrase 'exercising a function under this Act' in section A1(2) would apply to the appropriate audience. The group was conscious, for example, that nearest relatives and IMHAs could (it might be argued) be exercising a function under the Act.

C. ENFORCEMENT AND IMPLEMENTATION

The group concluded that, in addition to existing enforcement options such as tribunal consideration and CQC Mental Health Act reviews, consideration should be given to:

- Amending MHA section 139 (Protection for acts done in pursuance of this Act) so that breaching the principles could have a bearing on whether a person acted in bad faith or without reasonable care. The proposed amendment is:
 - 139 (1) No person shall be liable, whether on the ground of want of jurisdiction or on any other ground, to any civil or criminal proceedings to which he would have been liable apart from this section in respect of any act purporting to be done in pursuance of this Act or any regulations or rules made under this Act, unless the act was done in bad faith or without reasonable care **having regard, in particular, to section A1.**
- Including requirements in the code/legislation to record how the principles have informed decisions made and actions taken under the Act and amending the relevant forms to include a record of how the principles were taken into account:
 - At detention;
 - When care and/or treatment decisions are made;
 - At tribunal hearing; and
 - When considering CTOs etc.

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- Effective standardised training, recruitment and supervision would be needed to support implementation of the principles as evidenced by the CQC's latest review of the use of the current principles. NHS Improvement could have a role but other options would need to be considered to ensure that others acting under the Act, such as the police, were effectively trained. It was considered that this training would fall within the general need for updating training if the Act was amended.
- Amending section 118 of the Act to ensure commissioners and providers and other groups such as police are bound by any revised Code of Practice and using the Code to expand upon and provide illustrations of the principles. In particular, the group suggested:
 - Human rights considerations and the new statutory principles should be in a single chapter of the new Code.
 - The new Code should set out the regard that those acting under the Act should have to the families, carers and those involved in the individual's care and treatment process (including respect for patients who do not wish their families or friends to be involved in their care or treatment or who have no such support).
 - Clarify that equality encompasses ideas of equity ie that practitioners should seek to understand and provide patients with what they need to gain equality.
 - Be clear that the principles are intended to ensure reciprocity ie that if people are subject to involuntary detention and treatment they are entitled to care and treatment that will be of therapeutic benefit and will minimise harm.
 - That the term 'dignity' includes recognising, so far as is practicable, the personal dignity of the individual subject to the Act, the social dignity of that person's significant others, and dignity in the process in terms of decision-making under the Act.
 - That respect for diversity includes psychiatric diagnosis
 - Emphasising the importance of people having sufficient information to be able to take an active role in their care and treatment planning.
 - Clarifying that the word 'timely' in the principles does not mean that actions taken under the act should be rushed but that they should not be unnecessarily delayed or prolonged.

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3. RATIONALE

In reaching its decision that principles should be included in the Act, the group noted that the current principles found in the Code of Practice only apply to specified professionals (set out in section 118 of the Act) and that, as guidance, they can be departed from where there is (documented) reason for doing so.

In addition, the group considered evidence from the CQC's review of the current principles in the Code of Practice which found that there was a lack of awareness of the principles and individual responsibilities relating to them and that this meant that the principles are 'not being applied or monitored as well or as consistently as they should be across services'. Moreover, the CQC's review found, 'there is a lack of patient and carer awareness of the principles which means the likelihood of them raising challenge or concern when they are not applied to their care and treatment is minimal'. This evidence demonstrates how ineffective it is to have principles in a Code from which practitioners can depart.

The group also received evidence from academics, providers and advocates. Though some providers who responded showed some concerns about the potential for increased bureaucracy, there was support for having statutory principles from the other individuals consulted. The provider representative who attended a number of the meetings agreed that the current principles are not necessarily being applied consistently and supported the aims and outputs of the group.

There was no body of evidence on the effects of placing principles on the face of the Act. Unpublished research of tribunal reports in New South Wales, Australia, found that there was no statistically significant increase in those reports following the addition of capacity amongst the principles in section 68 of the Mental Health Act 2007. The statutory principles of the Mental Capacity Act are better known and often referred to in case law. The main cases where enforcing the principles could be said to have played a major role include:

- Principle 2 (practicable steps): *CH v A Metropolitan Council* [2017] EWCOP 12 – principle breach resulted in Article 8 ECHR breach, with compensation paid.
- Principle 3 (unwise decisions): *Kings College NHS Foundation Trust v C and V* [2015] EWCOP 80 – unwise to refuse renal dialysis but had capacity.
- Principle 5 (less restrictive): *Commissioner of Police for the Metropolis v ZH* [2013] EWCA Civ 69 – no defence to liability where disproportionate measures taken in best interests.

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In coming to their conclusions on the number and type of principles, the group considered a range of examples of legislation from both the UK and internationally which included principles and/or rights. These varied in length and issues covered (though principles of autonomy, involvement and least restriction appeared in many of the examples). The group also invited academics and care providers to talk to the group about a wide range of issues including cultural awareness and equalities and implementation and enforcement.

The view of the group was that a large number of principles could be difficult for practitioners and service users alike to understand, remember and, for practitioners, to embed in practice. This was backed-up by the review of the use of the principles by the CQC which concluded that 'there may be advantages in reducing the number of the guiding principles or simplifying them. These requirements are currently articulated in five principles, each with two concepts, for example, 'purpose and effectiveness.' It seems likely that this is one reason for the fact that staff do not know the principles by heart.'

The group considered including a specific principle to address the need for cultural awareness and appropriateness but concluded that the dignity of the patient if properly interpreted would encompass this crucial aspect. To highlight cultural awareness alone by adding a specific principle might be seen to diminish the overall scope of dignity.

Further the group considered that including a purpose would provide a statement of intent which those acting under the Act and those subject to it could use to inform their interpretation of its provisions. The wording agreed seeks to ensure that patients are seen as rounded individuals in line with the NHS Constitution statement to 'value each person as an individual, respect their aspirations and commitments in life and seek to understand their priorities, needs, abilities and limits'. It also reflects the group's agreement to, as far as possible, emphasise positive outcomes over minimising negative ones

As to implementation and holding to account, the group considered that putting the principles on the face of the Act would strengthen existing routes through which the principles could be respected (eg the courts, the tribunal, CQC visits and response to complaints). Importantly, the group concluded that linking breach of the principles to section 139 of the Mental Health Act was key to their implementation and effect. Section 139 provides procedural hurdles which potential litigants must overcome so as to avoid vexatious claims.

The CQC members of the group and practitioners highlighted the importance of including consideration of the principles on standard forms to ensure people are aware of their responsibilities with regard to the principles and to enforce recording and so enable auditing of their use.

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Scale/scope of the option/intervention

Including the crafted principles in the Act will positively impact on those subject to the Act and all actions made under it. They are drafted in such a way as to be more prescriptive than the current principles in the Code, thereby avoiding the present internal conflict where one principle has to be weighed against another. In the group's view, principles should not have to be compromised in this way but should instead be prescriptive, like those under the Mental Capacity Act 2005.

Funding/costs

Training and education will be needed as part of the training that will be generally required for a new or an amended Act.

Particular consideration will be required as to any financial impact (if at all) that might arise from commissioning bodies being required to comply with these statutory principles.

Improved experiences as a result of the inclusion of principles in the Act may lead to lower costs as a result of fewer, shorter, detentions. Our expectation is that these benefits will be considered alongside all the other changes being made to the Act.

Support/challenge

Incorporating principles into the Act is likely to be supported by service users, practitioners and advocates but there may be some push back from some providers who may consider it an additional bureaucratic burden. Cross-referencing a new section A1 with section 139(1) of the Act provides dentures – rather than teeth – to the principles. In other words, being able to use breached principles as evidence of bad faith or a lack of reasonable care gives them legal prominence. But, equally, those required to follow the principles are to a proper extent insulated from legal liability by the internal requirements of section 139.

Dignity and respect

The principles have been developed with a view to i) improving the experience of those subject to the Act by increasing their autonomy and their involvement in their care and in the decisions made with them, and ii) embedding a therapeutic, person-centred approach to care.

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Detention rates

Our crafted principles will positively impact upon medical recommendations and compulsory admission decisions more explicitly than at present. There is no guarantee of course that statutory principles will reduce detention rates since the reasons behind the increase are many. However, having statutory principles provides an important context in which the admission criteria will be considered. Moreover, effective implementation of the principles should lead to improved patient experience, may reduce the length of admission, and may lead to fewer people being re-detained.

Equality considerations, Black, Asian and Minority Ethnicities (BAME), Other

The group took evidence from service users and academics about the importance of cultural competence and appropriateness, understanding cultural trauma and the different physical impacts medicines could have on different ethnicities.

One of the principles concerns individuality, diversity and equality. Training, and culture change are likely to be needed to ensure that this principle is effectively implemented.

4. Implementation of recommendations

To implement these recommendations, the Mental Health Act would need to be amended to include a new clause (section A1) and an amendment to section 139. The Review may also want to consider the amendment of section 118 so as to remove 2A, 2B and 2C and to require commissioners (and providers) to have regard to the Code.

Amendments to the Code of Practice and incorporating the statutory principles in the wider training and education needed to implement the recommended changes to the Act is important to support implementation.

5. Evidence and analysis

The group considered:

- The CQC's 'Mental Health Act Code of Practice 2015: Evaluating how the guiding principles are being used by mental health service providers'.
- A sample review of use of the guiding principles undertaken by The Collaborating Centre for Values-based Practice in Health and Social Care, St Catherine's College, Oxford.
- Principles and rights in other jurisdictions including:

These are working documents produced by the Review's sub-groups. Please note that document style may therefore vary. See the Review's conclusions and recommendations in its final report, Modernising the Mental Health Act: Increasing choice, reducing compulsion

- Adults with Incapacity (Scotland) Act 2000
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Mental Capacity Act 2005
- UN Convention on the Rights of Persons with Disabilities (2006)
- Adult Support and Protection (Scotland) Act 2007
- Mental Health Act 2007 (New South Wales)
- Mental Health (Care and Treatment) Act 2008 (Singapore)
- Health Act 2009
- Equality Act 2010
- Mental Capacity Act 2010 (Singapore)
- Mental Health Act 2012 (Ghana)
- Care Act 2014
- Social Services and Well-being (Wales) Act 2014
- Mental Health Act (Malta)
- Northern Ireland: Mental Capacity Act (Northern Ireland) 2016
- Mental Healthcare Act 2017 (India)
- Substance Addiction Compulsory Assessment and Treatment Act 2017 (New Zealand)
- Analysis of enforcement of principles in other legislation.
- Domestic case law regarding domestic legislation.

Face-to face engagement with service users and carers

PUBLIC WORKSHOPS

The table below summarises the details of the seven public workshops held from February to October 2018.

A range of people attended the workshops, including but not limited to: service users, carers, clinicians, lawyers, police, advocates and social workers.

The first workshops were used by the Review to hear what people thought the big problems are with the current Mental Health Act.

The later workshops in August and October were used by the Review to test its emerging ideas and draft recommendations with attendees.

The verbal contributions gathered at all of the workshops was recorded and considered by the Review team, alongside hand-written attendee feedback. Additional email contributions were also provided by some of our attendees after the workshops had concluded.

The workshops consisted of a combination of plenary sessions, smaller break-out table discussions and then Q&A sessions with the workshop hosts.

Thanks again to those who took the time to travel to and attend the workshops, and contribute their views and experiences.

Month	Location
26th February	London
27th February	Newcastle
12th March	Cardiff
13th August	London
15th August	Liverpool
16th October	London
17th October	Exeter

Total number of attendees (approximately)	595 (average of 85 at each workshop)
Number of service user attendees (approximately)	120
Background/experience of workshop service user participants	Autism
	BAME
	Children and young people (carers of)
	Community-placed patients
	England and Wales
	Learning disability
	Male and female
	Low, medium and high security and forensic settings
Self-advocates	

FOCUS GROUPS

The table below summarises the numbers, locations and basic background/experience of the service users and carers who participated in the 50+ focus groups commissioned by the Review.

The focus groups took place in February-March and September-October 2018 and heard from specific groups of people (see details in the table below).

As with the workshops, the first phase of focus groups was used by the Review to hear what people thought the big problems are with the current Mental Health Act.

The second phase of focus groups was used by the Review to test its emerging ideas and draft recommendations with attendees.

The facilitating organisations submitted their write-ups of their focus groups to the Review team in October 2018, and this, alongside the workshop feedback referenced above, shaped decision-making during the production of the Review's final report.

Thanks again to the organisations below for running these groups on behalf of the Review.

Involved organisations	Broadland Clinic (Hertfordshire Partnership University NHS Foundation Trust)
	Broadmoor Hospital (West London NHS Trust)
	Camden and Islington NHS Foundation Trust
	Challenging Behaviour Foundation and Mencap
	Coventry and Warwickshire Mind
	Cumbria Partnership Trust Learning Disability Service
	Healthwatch Sheffield and Sheffield Advocacy Hub
	Hertfordshire Partnership University Foundation Trust
	Inclusion North
	Ludlow Street Healthcare Group
	National Autistic Taskforce
	NSUN
	Race Equality Foundation
	St Andrews Healthcare
	South Staffordshire and Shropshire NHS Foundation Trust
	Sussex Partnership NHS Trust
	Tees, Esk and Wear Valleys NHS Foundation Trust
	Together for Mental Wellbeing
	Touchstone Support Centre
	Voiceability
West London NHS Trust	

Locations	Berkshire
	Birmingham
	Cardiff
	Hertfordshire
	Leeds
	London
	Newcastle
	Northampton
	Staffordshire
	Sussex
	York
Number of service users	347
Number of carers	46
Alongside mixed workshops, workshops were held to hears views from specific groups of people	BAME
	Children and young people, and their parents
	Community-placed patients
	England and Wales
	Forensic patients, including those in low, medium, and high security, and the community
	Learning disability and/or autism
	LGBTQ
	Male and female
	Self-advocates

Response to call for evidence

Many thanks to the following who responded to our call for evidence:

- Seventy service users and carers who responded directly to our call for evidence. (Further information on our wider engagement with service users and carers, including our survey, focus groups, workshops, and Service User and Carers' Group, is available in the relevant sections of the Review's final report).

Organisations

- Agenda
- Alzheimer's Society
- Approved Mental Health Professional Lead Forum
- Association of Clinical Psychologists UK
- Association of Directors of Adult Social Care (ADASS) North West Mental Health Group
- Bipolar UK
- British Association of Social Workers
- British Institute of Human Rights (University of London)
- British Medical Association
- British Psychological Society
- Care UK
- Carers Trust
- Conroys Solicitors
- Biometric and Forensic Ethics Group, Home Office
- Royal College of Psychiatrists

- Clinical Reference Group for Adult Secure Services, NHS England
- Community Wellbeing Team, Local Government Association
- Crime in Mind
- Disability Rights UK
- Eastern Region Mental Health Crisis Care Concordat
- Edge Training & Consultancy Ltd
- Equality and Human Rights Commission
- Hafal
- Hammersmith & Fulham AMHP service
- hundredfamilies
- IMHA Society
- Independent Advisory Panel on Deaths in Custody
- Independent Custody Visiting Association
- INQUEST
- Institute of Alcohol studies, Centre for Mental Health
- Joint Commission on Human Rights
- JY Mental Health Associates
- Kate Mercer Training
- The Law Society
- Leeds Assertive Outreach Team, Leeds and York Partnership NHSFT
- London Mental Health Act Network
- Magistrates Association
- Mencap and Challenging Behaviour Foundation (CBF)

- Mental Health and Wellbeing Department, University of Warwick
- NHS Clinical Commissioners (Mental Health Commissioners Network, National Ambulance Commissioners Network), Association for Ambulance Chief Executives (AACE) and College of Paramedics, NHS Pathways
- Mental Health Foundation
- Mental Health Nurse Academics UK
- Mental Health Today
- Mental Health Tribunal Members' Association
- Mind
- Mills & Reeve LLP
- National Advocacy Conference Group
- National AMHP Leads Network
- National Audit Office
- The National Autistic Society
- National Collaborating Centre for Mental Health
- National Development Team for Inclusion
- National Institute for Health and Care Excellence
- National LGBT&T Partnership
- National Mental Health Nurse Directors Forum
- National Survivor User Network (NSUN)
- National training and advocacy qualification provider
- NHS England, Digital Mental Health team
- NHS England, Health and Justice
- NHS England, Safeguarding Programme team

- NHS Providers (including Appendix from Hertfordshire Partnership University Foundation Trust)
- Oxford Health NHS Foundation Trust
- Pathway
- Prisons and Probation Ombudsman
- Public Health team - NHS South Warwickshire Clinical Commissioning Group and Warwickshire County Council
- Race on the Agenda (ROTA)
- Rethink Mental Illness
- Royal College of Nursing
- Royal College of Occupational Therapists
- Royal College of Psychiatrists in Scotland
- Social Care and Social Work, Avon and Wiltshire Mental Health Partnership NHS Trust
- South London and Maudsley NHS Trust
- Speak Out Against Psychiatry
- Tribunals Judiciary
- YoungMinds

Health and/or social care professionals

- Advanced Clinical Practitioner, Betsi Cadwaladr University Health Board Wales Mental Health and Learning Disability
- Advanced Practitioner/AMHP from Adult Social Care, Poole
- AMHP Acting Lead, Wokingham Community Mental Health Team
- AMHP, Crisis Assessment Service, Leeds

- AMHP, Humber Teaching Foundation Trust
- AMHP Lead, London Boroughs of Richmond & Wandsworth, Wandsworth Borough Council
- AMHP Lead, Trafford Council/Greater Manchester Mental Health Foundation Trust
- AMHP, Mill View Hospital
- AMHP, North Yorkshire County Council x2
- AMHP, Service not stated x4
- AMHP, South Staffordshire and Shropshire
- AMHP Team Manager, Lambeth Centralised AMHP Service
- Associate Medical Director Inpatients South (Honorary Senior Clinical Lecturer), Northumberland Tyne and Wear NHS Foundation Trust (Newcastle University)
- Clinical Psychologist, Northumberland, Tyne & Wear NHS Foundation Trust
- Consultant Clinical Psychologist, Newtown, Wales
- Consultant Forensic Psychiatrist
- Consultant Forensic Psychiatrist & Honorary Senior Lecturer, Fixated Threat Assessment Centre (FTAC) & UCL Department of Security & Crime Science
- Consultant Paramedic from South Western Ambulance Service NHS Foundation Trust
- Consultant Psychiatrist, University of Manchester
- Consultant Rehabilitation Psychiatrist, Pennine Care NHS Foundation Trust
- Emergency Duty Service AMHP from Berkshire
- Forensic Psychiatrist, Norfolk and Suffolk NHS Foundation Trust and Visiting Professor from University of Chester
- Group Manager, Mental Health Social Work, St. Mary's Hospital, Newport, Isle of Wight
- Group Manager, Specialist Services

- Head of Service, Derby City AMHP Group, Derby City Council
- Head of Service Safeguarding (adults), London Borough of Hounslow
- Lead professional officer (Mental Health), Unite the Union
- Learning Disability nurse, York Mental Health Liaison Service, York District Hospital
- Locum consultant in adult psychiatry from Nottingham
- Mental Health Act Co-ordinator, Turning Point
- Mental Health Act Manager, Betsi Cadwaladr University Health Board
- Mental Health Social Care Lead/AMHP, Royal Borough of Kensington & Chelsea
- Mental Health Social Worker/AMHP from South Community Mental Health Team, Pennine Care NHS Foundation Trust
- Nurse Consultant, Northumberland Tyne and Wear NHS Foundation Trust
- Parliamentary Scholar/Trainee in General Adult and Old Age Psychiatry in South West London and St George's Mental Health NHS Trust
- Psychiatric Social Worker and Associate Hospital Manager
- Psychiatrist, Service not stated
- Researcher and AMHP, Southern Health NHS Foundation Trust
- Senior Manager (Policy), Wellbeing and Community Health Services, Northumberland Country Council
- Service Director, Milton Keynes Mental Health Services (part of Central and North West London NHS Foundation Trust)
- Social Work Lead, Adult Mental Health from Brent South Community Mental Health Team
- Social Worker/AMHP, Broadmoor Hospital
- Specialist Social Worker/AMHP, Hull Integrated Care Team for Older People
- Strategic Lead for Mental Health from Birmingham Adult Social Care

- Sutton Street Triage Nurse and Home Treatment Team Practitioner from Sutton, Merton and Wandsworth
- Trainee, Old Age Psychiatry
- Ward Manager, Bradford District Care NHS Foundation Trust

Other professionals

- Associate Hospital Manager, Appeals and Renewals, Bradford
- Clinical Legislation Manager, South West Yorkshire Partnership NHS Foundation Trust
- Compliance Manager, Cheshire and Wirral Partnership (CWP)
- Councillor, Basildon Borough Council
- Head of Mental Health Law, Barnet, Enfield and Haringey Mental Health NHS Trust
- Hospital Managers Panel
- Member of Parliament x 3
- Mental Health & Suicide Prevention Partnership Development Inspector (Office of the Chief Constable), North Yorkshire Police
- Mental Health Law Adviser, The Retreat Hospital, York
- Mental Health Law Manager, Cambridgeshire and Peterborough NHS Foundation Trust
- Mental Health Law Manager, Camden and Islington NHS Foundation Trust
- Mental Health Lead, Hampshire Constabulary
- Mental Health Liaison Officer, Avon and Somerset Constabulary
- Peer
- Practice Development Officer (Mental Health Law), Sussex Partnership NHS Foundation Trust
- Tribunal Judge, Mental Health Tribunal Members' Association (Member)

Academics and researchers

- Associate Professor, Northumbria Law School
- Co-Director of the Centre for Health, Law & Society, University of Bristol
- Emeritus Professor of Forensic Psychiatry, King's College London
- Emeritus Professor of Psychiatry and Society, King's College London
- Honorary Clinical Senior Lecturer, Newcastle University
- Law student and social worker, University of Cambridge
- Lecturer, Department of Social Work and Social Care, University of Birmingham
- Lecturer in Law, Lancaster University
- Lecturer in Law, University of Liverpool
- PhD student
- PolicyBristol, University of Bristol
- Professor Emeritus of Economic History, University of Oxford
- Professor of Law, Cardiff University
- Programme Lead (Senior research fellow and Independent Consultant), Social Work for Better Mental Health Programme (University of Leeds)
- Research and Development Department, Southern Health NHS Foundation Trust
- Research Fellow in Applied Moral Philosophy, University of Oxford
- Researcher, University Hospital Galway
- Senior Lecturer, Health Policy and Management, University of Birmingham
- Senior Lecturer, Imperial College London
- Social Work MSc student, University of York
- Wellcome Research Fellow and Lecturer in Law, Cardiff University