

Modernising the Mental Health Act

Increasing choice, reducing compulsion

**Final report of the Independent Review of the Mental Health Act 1983
– summary version**

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This is a summary of the Review's final report. The full report is available at:

<https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review>

INTRODUCTION AND EXECUTIVE SUMMARY: REVIEW CHAIR AND VICE CHAIRS

There is an increasing and welcome recognition in society today of the importance of poor mental health and its consequences for those who battle such challenges, their families and society. At the same time concerns have arisen about the nature of the care received by those with mental illness, and in particular about the rising levels of coercion within mental health services. This Review is a consequence of these concerns, and tries to address them.

In his foreword, the Chair of the Independent Review has already set out some of the background and problems that we face.

- The complex balance between respecting a person's autonomy and the duty of a civilised State to protect the vulnerable.
- The problem of fear – held by patients, the public, and professionals involved in the system.
- The rise of coercion and the continuing legacy of stigma, discrimination and racism in society.

It is now time to turn to the work of the Independent Review itself, and to provide an overview of our principal findings. This introduction and executive summary is aimed at those who wish to understand the overarching thinking that drove our detailed recommendations, which follow in the main body of the report and annexes.

No simple solution

Our starting point as we considered where change is necessary was to agree that there is no simple solution to the issue of autonomy versus protection. This is a fundamental tension that no amount of legislation, recommendations, reports or inquiries can ever solve - and our report is no exception to this. The reader will see that we have been careful in our recommendations to avoid absolute solutions as much as possible – in real life things are rarely so clear-cut that one can use the word "never".

But we do seriously want to rebalance the system to be more responsive to the wishes and preferences of the patient, to take more account of a person's rights, and to improve as much as possible the ability of patients to make choices even when circumstances make this far from easy.

In our Interim Report we already signalled that we were minded to retain a Mental Health Act, with compulsive powers, whilst being totally committed to shift towards a more rights-

based approach, improving respect and dignity, and ensuring greater attention is paid to a person's freely expressed wishes and preferences. Furthermore, we intended that all reasonable support will be available to enable patients to take their own decisions where that can be done. None of those positions have changed.

Restoring dignity to people and to the system

One of the recurring messages from our extensive engagement with service users is that the process of being detained under the Act is too often experienced as awful. **Just as truth is often described as the first casualty of war, the same is true of dignity when compulsive powers are being invoked.** The person affected, the service user, stands to lose authority over him or herself, loses self-determination and as a result, quite apart from other features of the system, can be stripped of their dignity and self-respect. This experience is not confined to crisis, for, in a mental health care system tested to its limits by the demands placed on it, human dignity can all too easily be lost to the daily pressures inherent in such a system.

Yet the dignity of the individual service user is more than just a desirable entitlement to decent treatment (though it is that). Dignity is essential both to improvement and to maintaining better health and reducing the risk of further admissions. Lack of dignity, and a lack of a trust that patients will be treated kindly and with respect, inspires fear. We have heard how many service users fear that being compulsorily admitted to hospital will worsen, not improve, their mental distress.

We accept that these fears are based on reality. This is understandably a powerful disincentive to early engagement with services - engagement that might help to avoid crisis. At its worst, some people fear that admission to a mental health ward or specialist learning disability hospital, may result in abuse, and even death. Again, we must acknowledge that both of these appalling eventualities have happened – lives have indeed been lost, and that loss has been particularly felt amongst those of black African and Caribbean heritage. So, if we are to have any chance of changing this, we must accept, as we do, that these fears are not without foundation¹, because only then can we start to rebuild a sense of trust that is essential if we are to combat fear and restore dignity. This has been central to our thinking throughout the Review.

¹ https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps01_18.pdf?sfvrsn=53b60962_4

We must improve choice and decision making, both prior to and within a setting of compulsion

We believe that improving patients' and service users' ability to make decisions about their own care and treatment is essential to upholding dignity. This theme runs throughout the report from start to finish. It underlies our recommendations, for example, on the importance of advance choices, and how these can become more common and more powerful. It is part of our recommendations on the right to advocacy, for those who find it difficult to make their wishes and preferences known and how these are particularly relevant for those at greater risk of discrimination, such as those from a minority ethnicity background. It is why we propose reforming the outdated system of choosing (which actually means not being able to choose) one's nearest relative. It underpins our suggestions for greater safeguards around compulsory treatment once admitted to hospital, and the more limited and nuanced uses of Community Treatment Orders (CTOs). It is a prime driver in our recommendations around statutory care plans, to be devised early and regularly reviewed. In short, it permeates all our thinking.

These recommendations are essential if we are to achieve a real shift in the balance of power between the patient and the professional, and make it easier for patients and service users to participate in decisions about their care. The extent of that participation will, of course, depend both on the person's mental capacity and their present state of health, and our proposals reflect this. Where a patient has capacity, our recommendations will ensure their wishes and preferences, whether expressed at the time or in advance, should only be overturned by the use of compulsory powers when absolutely necessary. In some circumstances, for example advance refusals to consent to treatments such as electroconvulsive therapy (ECT), we are recommending that this can only be changed by judicial decision. At all times, whether a patient has capacity or not, we are insisting that it becomes the norm to have the wishes and preferences of patients recorded, principally on the care and treatment plan, and that any reasons why these should not be followed, are recorded. This is an area where advocacy, whether through a formal IMHA or informally through a friend, family member, or the Nominated Person, will be particularly important. Much of this merely reflects current best practice but, sadly, we are in little doubt that this is far from standard, and that without our recommendations bad practice will continue.

The fundamental importance of human rights in mental health care

A crucial issue that has underpinned our engagement with others and continues to drive our thinking is that of human rights. We are obligated to comply with the Human Rights Act 1998 (which gives further effect to the European Convention on Human Rights (ECHR)), which is part of our domestic law, and with which we are arguably not fully compliant. We are also required to take into account other international conventions ratified by the UK. In particular, we have in mind the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). We have considered the issues arising from these obligations

throughout the Review, and say more in the How we are meeting our Human Rights Obligations section.

When human rights conflict

Knowing an individual's rights in specific circumstances should be straightforward. The difficulty comes when there is more than one right involved (e.g. the right to liberty versus the right to life) or when rights of others may conflict with the rights of the patient. Here we are required to strike fair balances, using the recognised concept of proportionality. Any government, or other body, must respect the rights of those in whose lives it sanctions intervention. At the same time, it may have other duties. It may be required to protect the lives of those contemplating serious self-harm or suicide. It must have regard to the safety of any others where there is a reasonably probable consequence of what a patient might do. These sorts of issues are the justification for the compulsive powers the state authorises and uses in this field. Our position is those interventions must be the least invasive or restrictive required to enable the state to fulfil its duties. An approach which focuses solely on the rights of one specific group can never be sufficient for a state concerned for the rights and safety of all. This is nothing new, as we consider below.

Supporting people from ethnic minority communities

One of the most troubling and difficult areas we have considered is the fact that those from ethnic minority communities are far more likely to be subject to compulsory powers under the Act, whether in hospital or in the community. Even amongst that group, black African & Caribbean men are significantly over represented. The profound inequalities that exist for people from ethnic minority communities in access to treatment, experiences of care, and quality of outcomes following mental health service care are longstanding. There has been much anxious thought why this should be the case and why this group does not have adequate access to, or else is reluctant to use, pre-crisis services. The answer (although not fully understood) is multifactorial, involving longstanding experiences of discrimination and deprivation, with a lack of understanding of the human dynamics of what is happening and some crucial gaps in trust between service users and providers. **We are in no doubt that structural factors which engender racism, stigma and stereotyping increase the risk of differential experiences in ethnic minority communities.** There is no single or simple remedy to resolve this situation, which is not unique to the health service in general, or mental health services in particular. A similar and equally depressing picture can be painted within our schools or criminal justice system or other aspects of modern society. No other issue has made us more aware of our fallibility than this one.

With that in mind we still hope that our recommendations will at least be a positive contribution. Be it as individual practitioners or system leaders, what is needed is honesty about the scale of the challenge, a recognition that current approaches are not delivering for people from ethnic minority backgrounds, and a firm commitment to work together with service users, carers and communities. This starts with having due regard for advancing

equality, as stated in the Public Sector Equality Duty², which is why amongst other measures we strongly support the creation of an Organisational Competency Framework (OCF) to tackle racial disparity, which has at its core service user and carer accountability measures, designed to address this. The OCF should focus on several core areas of competence: awareness, staff capability, behavioural change, data and monitoring, and service development (see the Experiences of People from Ethnic Minority Communities section). It is expected that there will be a role for regulatory bodies to monitor compliance and attainment at a national level, with patient and carer representatives having an active role in the assessment.

Principles that underpin our proposed reforms

The Mental Health Act gives significant powers, and its complexity can be confusing to those who use it, let alone those who are subject to it. As we set out in the following section, we have decided that it is important that the Act has clear fundamental principles and a purpose which should be articulated as its opening section. They would provide the basis for all actions taken under the Act, setting the standards against which decisions can be held to account and providing patients with clear expectations for their care and treatment. Such principles need to be both aspirational and enforceable, if they are to be on the face of the Act. They also need to be short and will necessarily be rather general. We propose they should enshrine the concepts of:

- Choice and autonomy – ensuring service users' views and choices are respected
- Least restriction – ensuring the Act's powers are used in the least restrictive way
- Therapeutic Benefit – ensuring patients are supported to get better, so they can be discharged from the Act
- The Person as an Individual – ensuring patients are viewed and treated as rounded individuals

The use of such principles has proved beneficial in the Mental Capacity Act and we think they should likewise guide the use of the state's powers under the Mental Health Act. As we think these should provide the basis for a reformed Act, we have structured our report around them.

² The Public Sector Equality Duty requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between people who have a protected characteristic and people who do not

Principle 1: Choice and Autonomy

We know how important it is to service users that their views and choices are respected, and we want to reflect this in the principles. We think a principle of Choice and Autonomy should include the need to support the person to express their will and preferences and to ensure that they are given proper weight in decision-making. We should also require professionals to respect the patient, their dignity and their social and caring relationships.

As stated above, we believe that essential to improving the dignity of patients and service users is improving their ability to make decisions about their own care and treatment. This is a theme that runs throughout the report, but it has particular relevance in three areas that have been collectively described as ‘game changers’ by many of the service users we have worked with.

Advance Choice Documents

The concepts in the Mental Capacity Act of advance decision-making and welfare powers of attorney should also apply in the context of the Mental Health Act. This is the view of most service users and again has received wide support from all the stakeholders we have consulted. It is a proper recognition of personal autonomy.

We propose the implementation of Advance Choice Documents (ACDs) in which patients and service users are encouraged to voice their views about any future inpatient care and treatment.

The distinction between an authenticated ACD and an informal expression of wishes and preferences is important when the question arises of when, if at all, such advance choices can be overruled. Where the communication has been informal, the views must be considered as part of a best interests assessment and if not followed, there should be a written record of reasons. They will not supersede the compulsory powers of the Act, but will be subject to review, through to the existing safeguards of a SOAD (provided earlier than the current 3 months), with the additional possibility of review by a Tribunal, as part of our general principle of moving the system towards greater recognition of wishes and preferences.

Where a person is recorded as having capacity at that time the choice is made, the presumption will be that it will be honoured unless there are compelling reasons why not. **So in future a request for a treatment that might be less than optimal, but still possible, should be honoured.** Requesting a treatment known to be harmful or ineffective could still be documented, but would not be implemented, and the same would apply to any ACD that contravenes the wishes expressed by Parliament regarding “assisted dying”. There will also be a clear route of challenge to a Tribunal available to a patient or their representative against individual treatment decisions.

We are proposing further safeguards – most particularly around electroconvulsive therapy (ECT). Some patients and service users have very strong views around this, and we have heard from some who feel that they would refuse ECT even if that imperilled their life. We have as a general principle adhered to a view that no ACD or expression of wish and preference can ever be 100% binding, for clear ethical and policy reasons, expressed earlier. However, certain interventions require even greater safeguards. So we propose that ACDs or other expressions of wishes around ECT could be overruled only by the authorisation of a judge (usually a High Court Judge) of the Court of Protection on strict criteria involving immediate risk to life, probably in circumstances where a person is now in a situation that they are unable to express any intention to change their mind - such as catatonia or depressive stupor.

We acknowledge that there is room for more than one reasonable view of these matters. We have made our choice in trying to respect autonomy without outraging the conscience of others. These matters are considered in detail in the Making Decisions about Care and Treatment section and Treatment choices annex.

Advocacy

We think there should be a right to advocacy based on an opt-out approach. A person in a mental health crisis, who is significantly unwell, or whose disability affects their ability to understand and communicate, needs the services of someone who sees things from their perspective and understands their rights. We regard this provision as essential. We also think this right should be extended to people who are informally admitted (as happens in Wales), to mitigate the risk of 'de facto' detention.

Nominated persons

There has been wide opposition to the current concept of the "nearest relative" and widespread support for the proposition that the patient should be able to choose their own "nominated person". We support this, with interim arrangements for those who are unable to make a nomination. We also think that to perform their function appropriately, a nominated person who objects to admission should not be faced with 'displacement' by default.

Principle 2: The Use of Least Restriction

The Mental Health Act enables people to be detained and treated against their will. The Least Restriction principle requires that the Act's powers are used in the least restrictive way, and that less restrictive alternatives must always be considered.

Avoiding detention and supporting people in crisis

Far and away the best way to improve the care and outcomes for those with the severest mental illnesses is to provide more and better alternatives to detention, leaving the areas that we are concerned with as the last resort, to be used as infrequently and for the shortest period of time possible.

The Review set out to identify examples of interventions that have succeeded in reducing the need for admission, either under the MHA or as a voluntary patient, which we could then recommend are expanded. However, we have only been able to draw provisional conclusions, and improved research and evaluation is needed to inform the future design, commissioning and funding of services and interventions. That said, the need for early and effective intervention to promote good mental health is uncontested.

We anticipate that the NHS Long Term Plan will be published soon. We have not seen the final details of this but have shared our emerging views with NHS England throughout the Review's lifetime. Nevertheless, we warmly welcome the general direction of travel, and especially the commitments to improvements in crisis and community mental health services, and the emphasis on improved community-based services for those with a learning disability, autism or both.

Broadly speaking, the quality of care provided once services have been accessed can be good; the difficulty lies in accessing services. Too many have had to conclude that it is a crisis rather than need that opens the door. This is a resource issue which is as much about lack of trained staff as it is about money. We therefore welcome the series of initiatives to encourage the young and indeed not so young (the decision to follow a career in mental health is often a later and more mature choice in many of the helping professions) to come forward into these areas of work. We are aware that it is easier to recruit less skilled personnel quickly, but our focus in this Review is on the needs of those with more severe, complex and long-standing problems, and for which creating the appropriate workforce must be a long-term project. In particular it will be important to recruit into the skilled workforce those who come from communities particularly disadvantaged within the present system- in particular from black African & Caribbean communities.

If access to good community services can have such a positive impact, why is there a reluctance to engage with community psychiatric services in some communities? There are many reasons including fear of outcome, fear of discrimination and the effects of multiple deprivation, which lead to poor relations with community facilities and a consequent lack of trust in those providing the service. That lack of trust is more likely to relate to institutional power than to the individual professional delivering the service. Once again we can only advocate a direction of travel, starting with a frank recognition of where we are, an acknowledgement of past failings and the determination to address it by

supporting initiatives designed to confront it. This is another matter of particular importance in relation to ethnic minority communities.

Opportunities for early intervention are missed too often. This leads to a person confronting crisis unsupported, and a further consequence of that is that increasingly the first contact is with the police rather than with healthcare. The police rightly recognise both that they have an important role to play in mental health crisis and also that they need to liaise closely with healthcare services. We support joint working including the use of vehicles with both the police officer and the healthcare worker aboard. We are recommending that police cells are no longer used as a Place of Safety for anyone of any age. That means that, where they do not currently exist, health-based places of safety will need to be commissioned. **We also recommend that courts should not remand to prison solely on the basis that it is a safe place for such people to be, for it simply is not.**

There is a pressing need to move people who present at A&E to a more appropriate facility quickly. However much they may need it, they cannot be detained under the Act until a proper assessment has been done. This may take time. That is why we support some amendment of the Mental Capacity Act to allow someone to be deprived of their liberty for a short while to allow psychiatric assessments to take place, mindful of recent tragedies in which this did not occur.

Care and treatment plans

We have heard time and again from people that they did not fully understand what was happening nor were their views sought, let alone considered during detention. We consider that there should be a duty on the Responsible Clinician (RC) to formulate a detailed care and treatment plan for each individual as soon as reasonably practicable (and reviewed within 14 days). That plan should govern everything up to and including leave and discharge. A key component of that plan should be the wishes and preferences of the patient, which should be considered and, if not followed, a record made of the reason why not. Different considerations might arise of course where there is an Advance Choice Document. All this is really no more than current best practice but, as it is a matter that may be considered in the challenge to detention, we believe it should be formalised.

Rights to challenge

Critical to our proposals are effective rights of challenge. We are recommending that these centre around the Mental Health Tribunal. We are recommending a series of changes that will strengthen this essential protection. The role of the Tribunal will be increased by the opportunity to scrutinise statutory care and treatment plans, the proposed shortening of the initial period of detention under section 3, the opportunity to hear treatment challenges, and by giving a right to seek a referral where there has been a significant change in circumstances. At the same time, we are making recommendations to improve the smooth

working of the system, for example ensuring that section 2 and section 3 are used appropriately, giving Tribunal Chairs better case management powers, whilst retaining current rights to a full hearing. Likewise, although a person may choose to opt out of attending an automatic referral to a Tribunal, that Tribunal may still go ahead as an essential safeguard.

We support the current composition of the Tribunal, subject only to extending the power of the Judicial Chair, sitting alone or dealing with the matter on paper, to make case management decisions. When considering a challenge to detention (the primary function of Tribunal), the Tribunal should be able to look broader than has previously been case, and be able to consider questions of care planning and treatment as part of that decision.

We also think the hospital managers' power of discharge is better carried out by a full judicial body – the Tribunal. We think that the Government should consider further how the scarce resource of associate hospital managers should be deployed, and whether it is necessary that they consider applications for renewal as they routinely do at present.

It is important that recommendations relating to Tribunal access are not seen in isolation from clinical care. The MHA operates in a complex and dynamic system, and changes to the balance of safeguards can have profound impacts on patient care. For example, it is well known that a large number of discharges take place in the weeks immediately preceding a Tribunal. By reducing the initial section 3 detention from 6 to 3 months, we expect not only to give earlier access to an additional Tribunal challenge but also to focus minds on the potential for earlier discharge in advance of it.

A new and essential safeguard – the right to an early challenge to compulsory treatment

A controversial question is the right of the patient to make a freestanding challenge to a course of specific compulsory treatment to which they object. At present a patient may have the benefit of a SOAD after three months. Should, however, the patient want to challenge the combined view of the two professionals, usually both doctors, the present system allows that only by Judicial Review. This is both exceptionally difficult and rarely utilised.

We propose far earlier access to a SOAD, as soon as the care and treatment plan is finalised, and that the patient be allowed to make a Tribunal challenge to a treatment decision, if both the RC and SOAD believe a treatment to be necessary. We strongly emphasise that we do not consider that, as a general rule, judges should be able to impose specific treatments on clinicians in this context, something that is opposed by both judges and clinicians. But we do think that human rights compliance should enable a patient to assert their right to object to a specific treatment provided, of course, that there is another treatment available, even if it may be sub-optimal.

The voluntary patient

We are concerned about the near demise of the "voluntary" or "informal" admission. Over the last few decades, the proportion of those in inpatient beds that are informal admissions has fallen relentlessly, due to two factors. First, as is well known, and a cause for celebration, the overall number of beds has reduced by over 90% since the start of the deinstitutionalisation in the 1960s. So inevitably those who now occupy beds are more likely to be severely ill and hence detained. Second, however, has been the change brought about by the 2007 amendments to the Mental Capacity Act and then the decision of the Supreme Court in "Cheshire West" in 2014. It is now necessary to provide a lawful justification for a deprivation of liberty in any person who lacks capacity and is today de facto "detained" in hospital, even if seemingly consenting to this situation. Almost unremarked upon has been the steady decline of informality in mental health settings despite the provisions of Section 131, which explicitly protects the status of informal patients.

It seems to us that the aspiration towards voluntary admission as the norm is worth asserting. First, we think that voluntary admission should be the first to be dealt with in the Act before coming to compulsory powers. Second, we discuss issues of advance consent to admission itself, whether expressed by way of Advance Choice Documents or through the appointment of a health and welfare attorney under the Mental Capacity Act. We have not made firm recommendations here, recognising that there are genuine disagreements that mandate wider consultation.

The interface with the Mental Capacity Act

For historical reasons the MHA and Mental Capacity Act have grown up separately and operate under different court structures. This makes for neither clarity nor simplicity. We recognise that in the short to medium term it would not be possible to merge the two systems (what is known as a "Fusion Act") and there is at present no firm agreement as to whether this would be a sound long-term aim (see "The future direction of travel" section). In the meantime, choices will have to be made as to which system to use in relation to decisions about detention and treatment where the patient lacks the requisite mental capacity.

We are firmly of the opinion that the decision should be made on the basis of whether the patient is "objecting" to what is proposed (using objecting in the usual sense of the word, as opposed to being unable to consent or dissent as in the sense of the Cheshire West judgment). That is a decision with which professionals are familiar, and is in keeping with the history and existing functions of the two Acts. It also has the virtue of simplicity – namely if objecting, the MHA should be used; if not and the person lacks capacity, the MCA. Of course, it is necessary to note the differences between the two regimes in terms of safeguards and after-care, differences that we believe are proportionate to the differences in intrusion into a person's life between the two Acts.

Some harmonisation could be achieved by "cross ticketing" judges of the Court of Protection and the Mental Health Tribunal to hear cases where a person is subject to both the MHA and the MCA, and by ensuring recognition in both regimes of advance decision making, and the position of those who hold powers of attorney and of deputies. All this must be considered in the context of the Liberty Protection Safeguards currently under consideration in Parliament. We have to recognise that in this area we are on shifting sand.

Community Treatment Orders

There is considerable controversy over CTOs which are being used far more extensively than had been anticipated when they were introduced in 2007. Ethnic minorities (and disproportionately amongst them black African & Caribbean men) are seriously over-represented. Action is required.

During the course of the Review we have become convinced that there are some service users for whom, despite our doubts, the CTO does play a constructive role. For these reasons we do not propose their abolition at this stage.

However, we think CTOs are significantly overused. We want to see a dramatic reduction in the number of CTOs, and for them to be used in a much more targeted way. We propose a tightening of criteria (and requiring both community and inpatient clinicians agree a CTO is necessary), an extension of the powers of the Tribunal to include dealing with conditions of a CTO, and making it particularly difficult to extend beyond two years without a compelling reason. We further propose that research is commissioned, which must report within five years, to see if these aims have been met. If the situation has not improved, then the argument for abolition would be difficult to resist. Expressed in the vernacular, **CTOs are in the "Last Chance Saloon"**.

Principle 3: Therapeutic Benefit

We have heard too often that people's experience of the Act can be damaging. We know that the nature of detention can in itself be traumatic and we want to be clear that people who are subject to the MHA should benefit from it. We think a Therapeutic Benefit principle should set out that services need to be delivered in a way that minimises the need for MHA powers to be used, and so that, where they are, patients are supported to get better so that they can be discharged from the Act.

Inpatient environments

Wards become people's home, often for many months, and so should offer a positive community for the patient where they can build new relationships. Sadly, people are often placed in some of the worst estate that the NHS has, just when they need the best. The

physical environment of wards has become affected by an increasingly risk- and infection-averse approach, which can create the kind of institutional atmosphere that psychiatry has been trying to move away from for the last half century. **We therefore call for new capital investment by the government and NHS to modernise the mental health estate.**

We argue that ward environments and ward cultures alike should support independence, social interaction and activity. These are all key to enabling people to get better.

Discharge

Good care planning is at the heart of ensuring the therapeutic benefit of detention. As set out above, a new statutory Care and Treatment Plan should be a cornerstone of the reformed Act. While this will have specific requirements during detention, a coordinated care planning process should stretch across all settings. Too often this is not the case.

Service users have reported poor experiences of being discharged, often without notice or any adequate aftercare and community services in place. In some circumstances this is in the middle of the night, without secure accommodation and before they feel well enough. The new Care and Treatment Plan during detention must include discharge planning, to ensure that from the point of detention inpatient services are thinking about the steps necessary to get someone back to their community.

Aftercare

We think everyone living in the community with a serious mental illness should have access to good support services. Currently section 117 aftercare creates an inequality in access. We have concluded that it would be wrong to address this inequality by limiting one of the few positive rights the current MHA brings. **Life is hard enough for those living with or recovering from severe mental illness without us making it even tougher.** Instead, we should level the playing field by making sure there is better access to long-term support to everyone to keep them well and prevent admission, especially as we hope to see far fewer people detained in the future. We are pleased that the NHS Long Term Plan is expected to emphasise the need for investment in community services for severe mental illness. In addition, new national guidance should be created to tackle the confusion that exists around section 117 entitlements at present, where Local Authorities and the NHS too often create ad hoc arrangements and engage in costly legal disputes.

Principle 4: The Person as an Individual

Service users have told us that they can feel that they are seen as a diagnosis rather than an individual. We think that a principle of the Person as an Individual will ensure that patients are viewed and treated 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'.

Ethnic minorities

As stated above, one of the most troubling and difficult areas we have considered is the fact that those from ethnic minority communities are far more likely to be subject to compulsory powers under the Act, whether in hospital or in the community.

We discuss this issue above and in depth in section 'The experiences of people from ethnic minority communities'. To repeat one of our core recommendations in this area, we strongly support the creation of an Organisational Competency Framework (OCF) for tackling racial disparity, which has at its core service user and carer accountability measures, designed to address this. We believe this method of holding organisations as a whole to account has the potential to deliver benefits across the MHA and beyond.

Children and young people

Children and young people are more likely than adults to be admitted informally to hospital. However, they are also more likely to be placed out of area, and may be placed in an adult unit. In these cases, we propose additional checks and safeguards, in the strongest terms.

We propose a position where the same functional test for ability to decide is applicable to all ages, with such ability being presumed for those over 16 (as the MCA provides) but needing to be established for those below 16. It is important to strike a fair balance between the rights of children and the rights of those who will care for them, where these rights conflict. Young people are more likely to follow the course of treatment when their rights and wishes are respected, but parents do need information and support if they are to be effective in supporting young people during detention and after discharge.

We are very mindful that our recommendation that parental consent should no longer be sufficient to allow treatment of a young person between 16 and 18 who has capacity may upset some parents, and be seen as going against our general desire to reduce coercion across the board. We do not think that this will lead to a single extra young person being detained in hospital. Instead what it will do is give them the protections and safeguards that would otherwise have been missing. We do sympathise with the possible reactions of some parents, and have drawn attention again to the relevant passages of the Code of Practice, that reinforce the vital role that working with parents must play in the care of any young person

People with learning disabilities, autism or both

We have been told that the Mental Health Act isn't providing the right type of support and care for people with learning disabilities, autism or both. The Mental Health Act is being used in a way that is not in line with its intended purpose, and is too often being used to compensate for the lack of adequate and meaningful support within the community.

The overall effect of the changes that we are recommending should be to help tackle the long-term warehousing of patients and ensure that being detained has a therapeutic benefit for the person. This includes, for example, the statutory care and treatment plan, the tightening of the detention criteria and what can be considered 'treatment', nominated person and requirement to make reasonable adjustments.

There is a clear consensus that what is most important is sustained long term investment in alternatives to detention, a view we endorse. That is why we are recommending a new duty on health and social care commissioners to collaborate to provide sufficient community based alternatives to detention for those with learning difficulties, autism or both, and to facilitate timely discharge.

We have considered whether learning disabilities and autism spectrum disorder should remain within the Mental Health Act. We heard moving testimony concerning the adverse consequences that have arisen following detention, and agree that the status quo is not an option. But is the solution to redefine these conditions as outside the MHA? There seems no clear consensus on this, and we have heard also about the many negative consequences that could arise from being outside this framework. It is a fine balance. There are cases when the Mental Health Act has been the only option at a point of crisis. Not only has it been the only option, it's been the only option that worked for the patient. We have ultimately been persuaded that the risk of completely removing learning disabilities and autism from the Act is too high, although we think this should be kept under review.

The Mental Health Act and the criminal justice system

A further major area of consideration has been the relationship between mental health services and the criminal justice system, and in particular the provisions of Part III of the Mental Health Act. There is common ground that those with serious mental illness should be in hospital and not in prison. There are, however, real difficulties within the system.

First, too many of those who are mentally ill are remanded to prison rather than to hospital. That could be addressed in part by prohibiting the use of prison as a place of safety solely on welfare grounds when bail is being considered, and extending hospital remand powers to the Magistrates Court; we would support both proposals. However, all these powers are illusory if no bed is available and that is frequently the case. This is an issue that commissioners need to address urgently.

Our second, linked, point is that health and justice partners need to make some changes in the way patients who are detained under Part III of the Act are managed. **Put simply, if these processes can be sped up, it would permit an easier and swifter transfer of those with severe illness from prison to hospital and on through the secure hospital system.** To this end, we recommend introducing new time limits for transferring mentally ill prisoners to hospital.

In addition, large numbers of prisoners experience one or more mental illnesses or disorders and require care in the secure hospital system. The numbers whose condition leads to serious risk, either to themselves or others, is very much smaller. It is important not to conflate the two groups. We recommend low risk decisions concerning leave and transfer of restricted patients should be taken by the responsible clinician rather than the Justice Secretary, who should instead be informed and have powers of override. These matters will require further consultation.

What we say about prison should also apply in principle to those held in Immigration Removal Centres.

The position in Wales

We have been dealing with a review of the UK Government's responsibilities under the Mental Health Act in England and Wales. The UK Government is responsible for health policy in England, and justice policy across England and Wales. The Welsh Government may be interested to follow similar reforms, but because of devolution questions, each set of proposals will have to be tested specifically for Welsh application and modified as necessary. The Mental Health Review Tribunal for Wales is, for historical reasons, organised differently, so it will be more difficult to assume the greater responsibilities for the Tribunals that we are recommending and some special arrangements will be needed. However, given the number of patients placed across borders, alignment between England and Wales will be a significant priority.

We were very encouraged to hear of constructive discussions taking place between the Presidents of Tribunal in England and Wales with a view to addressing these issues.

Acting on this report

Taken as a whole we believe that our recommendations would mean that the Act will look and feel very different. There will be greater safeguards and a greater respect for wishes and preferences. All of these will be underpinned by changes to accountability, challenges and transparency.

It is important to view our recommendations in the context of wider investment in, and reform of, services for people with severe mental illness, learning disability, and/or autism. Compulsory treatment must be a last resort, and the coercion involved places an additional responsibility to ensure the quality of services is high. The NHS Long Term Plan will therefore be critical to our entire report – the two cannot be considered apart.

Mental health legislation is some of the most challenging and complex legislation that any government faces. It must have careful and prolonged scrutiny. The number of stakeholders is vast – we have done our best to consult as many as possible but, of course, there are always more voices and more views. As far as possible this area is not one that should be decided by traditional party-political concerns – again we have done our best to present a set of recommendations that can be accepted across the political spectrum. We have only made recommendations where we feel there is at least a reasonable chance of a broad consensus being achieved.

Last words

We have consulted very widely among service users, carers, special-interest groups and professionals in compiling the material on which our conclusions are based. This has been an educative exercise for each of us who have our own comparatively narrow areas of experience and expertise. We hope that we have dealt faithfully with that material, though it is immediately apparent from everything we have learned that we could not please all of the people, all of the time.

So it is inevitable that our recommendations will not please everyone; indeed many may in some respect be disappointed. Sometimes our failure to recommend something may be that we simply do not think it would be right. Some may feel we have gone too far, yet more that this is not far enough. We have sympathy with the latter view, but have to accept that we needed to manage the tensions between autonomy and protection, and between aspiration and practicality – the health service we would like, and the one that can be funded. These tensions have compelled us to make choices. This Review will not and cannot deliver a perfect system. That is impossible, not least because there is no agreement on what it should be. What it does, however, aspire to deliver is a much improved system that, at its core, places the patient in higher esteem. It is on that basis that we recommend it.



Chair

Professor Sir Simon Wessely – Regius Professor of Psychiatry at King’s College London and president of the Royal Society of Medicine



Vice chairs

Steven Gilbert – Service user & Serious Mental Illness Living Experience Consultant

Sir Mark Hedley – retired high court judge

Rabbi Baroness Julia Neuberger – former CEO of the King’s Fund and Chair of the Liverpool Care Pathway Review

OUR RECOMMENDATIONS: AN ILLUSTRATIVE GUIDE

A person's journey through the Mental Health Act

If you are a service user, we expect your experiences of the Mental Health Act will be improved if the Review's recommendations are implemented.

The changes

Four principles will be put into law that must guide all decisions taken under the Act. These include giving more control and choice; providing therapeutic care; treatment being the least restrictive and invasive option; and people's differences being respected.

1



Advance Choice Documents are built into your routine care planning, including treatment refusals and preferences, and who to tell if they are detained. These choices will have legal protection if you are detained.

2



You can choose your 'nominated person', and choose other individuals to receive information about your care (rather than the current automatic 'nearest relative'). You can decide in advance or, where you are able, at the time.

3



You will only be detained if suffering from mental disorder and risk of harm to yourself or others is 'significant', and treatment is available in hospital.

4



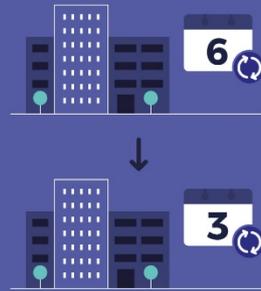
Detention decisions must be explained to you and formally recorded, including how your advance choices have been reflected.

5



There will be new care and treatment plans with a legal footing. This will quickly establish what you need, and how this will be provided – including regard to your wishes and preferences and planning for discharge. If these are not followed, you can challenge at a tribunal.

6



Initial time limit for a section 3 would be reduced from six months to three months.

7



More frequent tribunal access, including where there has been a change in circumstances. Earlier automatic tribunal hearings for those who have not applied themselves and more opportunities for referrals to be made on your behalf.

8



Improved discharge planning, involving the individual and their nominated person, and more integrated care planning.

9



Community Treatment Orders are used much less frequently and require the agreement of the inpatient clinician, community clinician and an Approved Mental Health Professional. It is subject to frequent automatic review at a tribunal, which can alter conditions.

OUR RECOMMENDATIONS: FULL LIST

New Mental Health Act Purpose and Principles

- 1. A purpose and a set of principles should be included in the Act itself.**
- 2. There should be four new principles covering: choice and autonomy, least restriction, therapeutic benefit, and the person as an individual.**
- 3. MHA regulations and forms should be amended to require professionals to record how the principles have been taken into consideration, and to enable local auditing and monitoring and CQC to consider this as part of their monitoring and inspection role.**

Principle 1 – Choice and autonomy

Making decisions about care and treatment

- 4. Shared decision-making between clinicians and patients should be used to develop care and treatment plans and all treatment decisions as far as is practicable.**
- 5. It should be harder for treatment refusals to be overridden, and any overrides should be recorded, justified and subject to scrutiny (see Annex on Treatment Choices).**
- 6. Statutory advance choice documents (ACDs) should be created that enable people to make a range of choices and statements about their inpatient care and treatment. These should be piloted to identify the detail needed to inform/impact practice.**
- 7. Decisions about medication should, wherever possible, be in line with the patient's choice and patients should have a right to challenge treatments that do not reflect that choice.**
- 8. Patients should be able to request a Second Opinion Appointed Doctor (SOAD) review from once their care and treatment plan has been finalised or 14 days after their admission, whichever is the sooner; and again, following any significant changes to treatment.**
- 9. Patients should be able to appeal treatment decisions at the Mental Health Tribunal following a SOAD review.**

10. The Government and the CQC should consider ways to resource the likely increase in SOAD reviews, looking at how the model of SOADs can evolve.
11. The Government should consult upon:
 - a. whether the MHA should provide that a person can consent in advance to confinement for medical treatment for mental disorder, or to empower an attorney or court appointed deputy to give consent on their behalf; and
 - b. what safeguards would be required.
12. Mental healthcare providers should be required to demonstrate that they are co-producing mental health services, including those used by patients under the MHA.

Family and carer involvement

13. Patients should be able to choose a new Nominated Person (NP) to replace the current Nearest Relative (NR) role under section 26 of the MHA.
14. A new Interim Nominated Person (INP) selection mechanism should be created for those who have not nominated anyone and do not have capacity to do so.
15. Patients should have greater rights to choose to disclose confidential information to additional trusted friends and relatives, including through the NP nomination process or advance choice documents.
16. NPs should have the right to be consulted on care plans.
17. Patients under Part III of the MHA who are not currently eligible to have a NR should have limited eligibility for a NP/INP in relation to care planning.
18. The county court power to displace a NR should be replaced with a Mental Health Tribunal power to overrule or displace a NP, and only contested nominations should be heard in court.
19. NPs and INPs should be consulted about a renewal of a patient's detention, extension of a community treatment order, transfer from one hospital to another, and discharge, rather than simply notified.
20. NPs should have a power to challenge treatment before the Mental Health Tribunal where the patient does not have capacity to do it themselves.

21. NPs should be given improved support, which could include courses provided by recovery colleges, support lines or online materials.

Advocacy

22. The statutory right to an Independent Mental Health Advocate (IMHA) should be extended so that it includes:

- a. all mental health inpatients, including informal patients;**
- b. patients awaiting transfer from a prison or an immigration detention centre;**
- c. people preparing their advance choice documents (ACDs) that refer to detention under the Mental Health Act.**

23. IMHA services should be 'opt out' for all who have a statutory right to it and the CQC should monitor access.

24. The statutory definition of IMHA advocacy should be amended to cover advocacy around care planning and advance choice.

25. Further consultation should be undertaken on the training of advocates and quality standards, balancing the requirement for better quality services overall with the need for tailored interventions for specific groups.

26. Commissioning by local authorities should be strengthened, so that:

- a. guidelines make it clear that IMHAs are best placed to provide support in cases where there is an overlap with Care Act / MCA advocacy;**
- b. services are commissioned on the basis of existing quality standards;**
- c. providers are required to provide quarterly reports to their commissioners about issues and trends, incorporating input from trust staff, families/carers and clients;**
- d. the requirement for IMHAs to be available to meet the needs of different groups, particularly ethnic minority communities, is strengthened, in light of the Public Sector Equality Duty.**

Complaints

- 27. Section 132 of the MHA should be amended to require managers of hospitals to provide information on making complaints to patients and their nominated person.**
- 28. Staff dealing with complaints should have an understanding of the MHA so they are aware of the particular impact of detention.**
- 29. Information going to hospital boards should be separated between complaints made by patients detained under the MHA and complaints made by informal patients.**
- 30. The Government and CQC should take steps to improve the systems that handle complaints from patients and their carers across providers, commissioners, police and local authorities to improve transparency and effectiveness across the system.**
- 31. Local Safeguarding Adult Boards should ensure that safeguarding arrangements support organisations to discharge their safeguarding duties and ensure that there are effective processes in place to identify, investigate and take action on safeguarding issues**

Deaths in detention

- 32. A formalised family liaison role should be developed to offer support to families of individuals who die unexpectedly in detention.**
- 33. Families of those who have died should receive non-means-tested legal aid.**
- 34. Guidance should make clear that a death under Deprivation of Liberty Safeguards (DoLS)/Liberty Protection Safeguards (LPS) in a psychiatric setting should be considered to be a death in state detention for purposes of triggering the duty for an investigation by a coroner and an inquest with a jury should be held.**

Principle 2 – Least Restriction

Tackling the rising rates of detention

- 35. There should be more accessible and responsive mental health crisis services and community-based mental health services that respond to people's needs and keep them well.**

36. Research should be carried out into service models and clinical/social interventions that affect rates of detention.
37. The Government should resource policy development looking into alternatives to detention, and prevention of crisis.
38. 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, NHI, ADASS, LGA, patients, carers and provider boards, to understand the cultural drivers behind their different conceptualisations of risk and how they can be harmonised.

Criteria for detention

39. People should be treated as an inpatient with consent wherever possible. In order to give the informal admission more prominence section 131 of the MHA should be moved so that it sits above sections 2 and 3 of the Act.
40. A patient's capacity to consent to their admission must always be assessed and recorded, including on the application form.
41. In order to be detained under the MHA, the patient must be objecting to admission or treatment. Otherwise they should be admitted informally or (as set out further under 'Deprivation of Liberty: MCA or MHA?') be made subject to an authorisation under the framework provided for under the MCA.
42. Detention criteria concerning treatment and risk should be strengthened to require that:
 - a. treatment is available which would benefit the patient, and not just serve public protection, which cannot be delivered without detention; and
 - b. there is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person without treatment.

A statutory Care and Treatment Plan

43. Detention should require a comprehensive statutory Care and Treatment Plan (CTP) to be in place within 7 days and reviewed at 14 days. This should set out:
 - a. the full range of treatment and support available to the patient from health and care organisations;

- b. any care which could be delivered without compulsory treatment;**
- c. why the compulsory elements are needed;**
- d. what is the least restrictive way in which the care could be delivered;**
- e. any areas of unmet need (medical and social);**
- f. planning for discharge (including a link to the Statutory Care Plan recommended in the Care Planning and Aftercare chapter);**
- g. how specifically the current and past wishes of the patient (and family carers, where appropriate) have informed the plan;**
- h. any known cultural needs.**

Length of detention

- 44. The Code of Practice should be amended so that, where a person has been subject to detention under section 3 within the last twelve months, an application for detention under section 2 can only be made where there has been a material change in the person's circumstances.**
- 45. The Code of Practice should make it clear that section 3, rather than a section 2, should be used when a person has been already subject to section 2 within the last twelve months.**
- 46. The detention stages and timelines should be reformed so that they are less restrictive through:**
 - a. introducing a requirement for a second clinical opinion at 14 days of a section 2 admission for assessment;**
 - b. extending the right of appeal for section 2 beyond the first 14 days;**
 - c. reducing the initial maximum detention period under section 3 so that there are three detention periods in the first year of 3 months, 3 months and 6 months;**
 - d. introducing a new time limit by which a bed must be found following an order for detention;**
 - e. requiring the responsible clinician and the Approved Mental Health Practitioner (AMHP) to certify 10 days in advance of a Tribunal hearing**

for section 3 that the patient continues to meet the criteria for detention.

Challenging detention

47. The tribunal should have the power, during an application for discharge, to grant leave from hospital and direct transfer to a different hospital, as well as a limited power to direct the provision of services in the community.
48. Where the tribunal believes that conditions of a patient's detention breaches the Human Rights Act 1998 they should bring this to the attention of the CQC (or HIW in Wales).
49. Tribunal should be given performance information by their local providers.
50. A statutory power should be introduced for Independent Mental Health Advocates and Nominated Persons to apply for discharge to the Tribunal on behalf of the patient.
51. A power should be introduced for SOADs and the CQC to refer a patient to the tribunal following a change in circumstances. This would expand, but not replace the current powers of the Health Secretary under section 67 of the Act.
52. There should be an automatic referral to the tribunal 4 months after the detention started, 12 months after the detention started, and annually after that.
53. For part III patients, automatic referrals should take place once every 12 months.

Deprivation of liberty: MCA or MHA?

54. Only the MCA framework – Deprivation of Liberty Safeguards (DoLS), in future the Liberty Protection Safeguards (LPS) – should be used where a person lacks capacity to consent to their admission or treatment for mental disorder but it is clear that they are not objecting.
55. A patient could be held in hospital for a statutory period of up to 72 hours under MCA LPS amendments whilst it is determined whether the person is objecting.
56. Amendments to the MCA, the Codes of Practice, and relevant procedures before the Court of Protection and Tribunal should be made to clarify the position in relation to those in the community subject to both the MCA and the MHA. Dual authorisation under s.17 MHA and DoLS/LPS should not be required.

Community Treatment Orders

- 57. The criteria for Community Treatment Orders (CTOs) should be revised in line with detention criteria.**
- 58. The onus should be on the responsible clinician to demonstrate that a CTO is a reasonable and necessary requirement to maintain engagement with services and protect the safety of the patient and others. The evidence threshold should be raised for demonstrating that contact with services has previously declined, and that this led to significant decline in mental health.**
- 59. Applications for a CTO should be made by the inpatient responsible clinician, with the community supervising clinician who will be responsible following discharge, and an Approved Mental Health Practitioner (AMHP).**
- 60. The Nominated Person/ Interim Nominated Person will have the power to object to both applications and renewals of CTOs.**
- 61. CTOs should have an initial period of 6 months, renewed at 6 months and then 12 months. Each renewal must involve two approved clinicians and an AMHP, unless the tribunal has recently reviewed the order.**
- 62. CTOs should end after 24 months, though the responsible clinician should be able to make a new application.**
- 63. As well as considering discharge, the Tribunal should, when refusing to discharge from the CTO, be able to order changes to the conditions of a CTO.**
- 64. If no appeal is made to the Tribunal in each time period there will be an automatic referral.**
- 65. The recall criteria should be updated and the process should be reformed to make it simpler.**
- 66. Recall to alternative locations should be considered.**
- 67. As set out in our chapter on Advocacy, Independent Mental Health Advocate services should be commissioned specifically for people on CTOs that requires providers to proactively approach the patient and offer their services.**
- 68. If put in place, the effect of our recommendations on CTOs should be reviewed in no more than five years' time, with a view to abolish CTOs if outcomes are not improved.**

Coercion and restrictive practices within inpatient settings

- 69. Wards should not use coercive behavioural systems and restrictions to achieve behavioural compliance from patients, but should develop, implement and monitor alternatives.**
- 70. Providers should take urgent action to end unjustified use of 'blanket' restrictions applied to all patients.**

Principle 3 – Therapeutic Benefit

Care planning/aftercare

- 71. There should be a Statutory Care Plan (SCP) for people in contact with Community Mental Health Teams, inpatient care and/or social care services.**
- 72. There should be a statutory duty for CCGs and Local Authorities to work together to deliver the SCPs.**
- 73. Discharge planning should be improved, as part of the Care and Treatment Plan during detention, to ensure it is being considered from day one, and should be recorded and updated in the SCP post detention.**
- 74. There should be better access to long-term support for everyone to keep them well and prevent admission.**
- 75. There should be a clear statement in the new Code of Practice of the purpose and content of the SCP and section 117 aftercare.**
- 76. There should be national guidance on how budgets and responsibilities should be shared to pay for section 117 aftercare.**
- 77. The effectiveness of joint working arrangements should be subject to monitoring and review by the Care Quality Commission.**

Hospital visitors

- 78. The managers of the hospital should continue to have the duty to scrutinise applications for detention, and should have a duty to scrutinise renewal documents.**
- 79. The power of associate hospital managers to order discharge following a hearing should be removed.**

80. The Government and the CQC should consider developing a new independent 'Hospital Visitors' role, the main purpose of which is to monitor day-to-day life in the hospital and ensure that patients are treated with dignity and respect.
81. The managers of the hospital (those who actually manage the hospital) should continue to have the power to discharge a patient where fundamental errors have been made in either the admission or renewal paperwork.

Inpatient social environments

82. The CQC should develop new criteria for monitoring the social environments of wards. These criteria should be the yardstick against which wards are registered and inspected and this should be reflected in ratings and enforcement decisions.
83. Patients should have a daily one-to-one session with permanent staff in line with NICE guidelines.

Inpatient physical environments

84. The physical environment of wards needs to be improved, through co-design and co-production with people of relevant lived experience, to maximise homeliness and therapeutic benefit and minimise institutionalisation.
85. The prompts and guidelines currently used for inspections in the assessment frameworks specific to mental health inpatient care should be reviewed with input from patients and their carers.
86. Risk assessments of issues such as infection control should be designed specifically for mental health inpatient care, and not lifted from other health settings. The unintended psychosocial effects must also be considered.
87. A review should be undertaken of the physical requirements for ward design for mental health units (e.g. the building notes, regulatory standards). The design of this review should be co-produced with people with lived experience.
88. The backlog of maintenance and repairs needs to be addressed so that mental health facilities are brought up to standard.
89. The government and the NHS should commit in the forthcoming Spending Review to a major multi-year capital investment programme to modernise the NHS mental health estate.

90. All existing dormitory accommodation should be updated without delay to allow patients the privacy of their own room.
91. The definition of single sex accommodation should be tightened up to ensure a genuinely single sex environment with separate access to any shared daytime space.

Principle 4 – The Person as an Individual

Person centred care

92. The CQC should review and update their inspection and monitoring of individual treatment and care to provide assurance that it meets the needs of people in different equality groups.
93. Reasonable adjustments should be made to enable people to participate fully in their care, including in relation to communication abilities.
94. A patient's physical health should be monitored, so that physical illness and conditions (e.g. diabetes and asthma) can be identified and treated.
95. The CQC should pay particular regard to obtaining patient (and carer) input from those who might find it difficult to articulate their views, including those in secure and out-of-area placements, those with learning disabilities or autism, children and young people.

Recognition of patient individuality at the tribunal

96. Training should be developed for panel members in specialisms including children and young people, forensic, learning disability, autism, and older people.
97. Statistics should be collected on the protected characteristics of those applying for a Tribunal hearing, and their discharge rates.

The experiences of people from ethnic minority communities

98. An Organisational Competence Framework and Patient and Carer (Service User) Experience Tool should be implemented across health and care services. This should build upon ongoing work by NHS England to develop the Patient and Carer Race Equality Framework (PCREF).
99. Regulatory bodies such as the 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.

- 100. 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.**
- 101. Safeguards should be created so that patients are able to continue religious or spiritual practices while detained in hospital. These should prevent the use of restrictive practices that limit a person's access to religious observance.**
- 102. 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.**
- 103. 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.**
- 104. Behavioural interventions to combat implicit bias in decision-making should be piloted and evaluated.**
- 105. 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.**
- 106. 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.**
- 107. A call for research should be made into tailored early interventions for African and Caribbean children and young people, particularly those at risk of exclusion from school.**

Children and young people

- 108. Legislation and guidance should make clear that the only test that applies in relation to those aged 16/17 to determine their ability to make decisions in relation to admission and treatment is that contained in the Mental Capacity Act.**

- 109. In young people under 16, competence should be understood in this context as the functional test under the Mental Capacity Act, although without the presumption of capacity that applies in relation to those over 16.**
- 110. Young people aged 16 or 17 should not be admitted or treated on the basis of parental consent. The MCA (LPS) or MHA should be used as appropriate if they are unable to consent to their treatment.**
- 111. Government should consult on the ability of parents to consent to admission and treatment for those under 16.**
- 112. Every inpatient child or young person should have access to an Independent Mental Health Advocate who is trained to work with young people and their families.**
- 113. Every inpatient child or young person should have a personalised care and treatment plan which records the views and wishes of the child or young person on each issue. Government should consider whether there should be a statutory duty for such a plan where the child or young person does not already have either a statutory care plan or a Care and Treatment plan under the MHA.**
- 114. Initial Reviews should take place within five days of emergency admission (or three days if it is to adult facility) and at a minimum of four-to-six weekly intervals after that.**
- 115. For children/young people placed in an adult unit, or out of area, the CQC should be notified within 24 hours. The CQC should record both the reasons for placement and its proposed length.**
- 116. Government should consider making it a requirement that the parents and families of young people placed out of area are supported to maintain contact.**
- 117. Section 17 of the Children Act 1989 should be amended to clarify that any child or young person admitted to a mental health facility is regarded as a 'child in need' so that parents can ask for services from their local authority.**
- 118. The local authority for the area in which the child or young person ordinarily lives should be notified if a child or young person is placed out of area or in an adult ward or if admission lasts more than 28 days. For 'looked after children', paragraph 14.97 of the Code of Practice will continue to apply.**
- 119. Where data is recorded it should be split into age groups.**

People with learning disabilities, autism or both

- 120. Health and social care commissioners should have a duty to collaborate to ensure provision of community based support and treatment for people with a learning disability, autism, or both to avoid admission into hospital and support a timely discharge back into the community.**
- 121. Amend the MHA Code of Practice to clarify best practice when the MHA is used for people with autism, learning disability or both.**
- 122. Care and Treatment Reviews should be given statutory force in the MHA.**
- 123. The Mental Health Services Dataset should include specific data to monitor the number of detentions and circumstances surrounding that detention of people with autism, learning disabilities or both.**

Policing

- 124. By 2023/24 investment in mental health services, health-based places of safety and ambulances should allow for the removal of police cells as a place of safety in the Act, and ensure that the majority of people detained under police powers should be conveyed to places of safety by ambulance. This is subject to satisfactory and safe alternative health based places of safety being in place.**
- 125. Ambulance services should establish formal standards for responses to section 136 conveyances and all other mental health crisis calls and ambulance commissioners and ambulance trusts should improve the ambulance fleet, including commissioning bespoke mental health vehicles.**
- 126. The responsibilities of NHS commissioners under section 140 of the Act must be discharged more consistently and more effectively, so that emergency beds are available.**
- 127. NHS England should take over the commissioning of health services in police custody.**
- 128. Equality issues, particularly police interactions with people from ethnic minority communities under the MHA, should be monitored and addressed. This should be under the proposed Organisational Competence Framework where possible.**

Patients in the criminal justice system

- 129. Magistrates' courts should have the following powers, to bring them in line with Crown Courts:**

- a. remand for assessment without conviction under section 35 of the Mental Health Act (MHA);
- b. remand for treatment under section 36 of the MHA;
- c. the power to commit a case to the Crown Court for consideration of a restriction order following an 'actus reus' finding;
- d. 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.

130. Prison should never be used as 'a place of safety' for individuals who meet the criteria for detention under the Mental Health Act.
131. A new statutory, independent role should be created to manage transfers from prisons and immigration removal centres.
132. The time from referral for a first assessment to transfer should have a statutory time limit of 28 days. We suggest that this could be split into two new, sequential, statutory time limits of 14 days each: i) from the point of initial referral to the first psychiatric assessment; ii) from the first psychiatric assessment until the transfer takes place (this incorporates the time between the first and second psychiatric assessment and the time to transfer).
133. Decisions concerning leave and transfer of restricted patients should be categorised by the Ministry of Justice according risk and complexity. Straightforward and / or low risk decisions should be taken by the responsible clinician. The Ministry of Justice would have 14 days to override this decision.
134. The new statutory Care and Treatment Plan should include a plan for readmission and consider what factors should be taken into account concerning use of informal admission, section 2 and recall.
135. The powers of the Tribunal should be expanded so that they are able, when deciding not to grant an application for discharge, to direct leave or transfer.
136. The Government should legislate to give the Tribunal the power to discharge patients with conditions that restrict their freedom in the community, potentially with a new set of safeguards.

137. There should be an automatic referral for people on conditional discharge to the tribunal after 12 months and at regular intervals after that for patients who have not applied directly.
138. The Government should consider giving the Parole Board Tribunal status and combining hearings where appropriate. At the very least the Government should streamline processes so that hearings could be convened back to back.
139. 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.

Immigration Detention

140. The new statutory, independent role for prison transfers should be extended to consider the least restrictive option for immigration detainees, including treatment in the community, informal admission and civil sections of the MHA.

Victims

141. The Department of Health and Social Care and the Ministry of Justice should work together to remove the gap in provision of information to victims of crimes committed by unrestricted patients, and to make sure victims are aware of their ability to make impact statements to the Tribunal in appropriate cases.

System-wide enablers

Data

142. An agreed, accurate national baseline of use of the MHA should be established following a pilot programme to develop robust methodology.
143. A new official national dataset of Approved Mental Health Practitioner (AMHP) activity should be created and integrated into the NHS Digital Mental Health Services Data Set.
144. Key data from the NHS Digital Mental Health Services Data Set should be published monthly as close to real time as possible.

145. Data on police use of detention powers under the MHA (sections 135 and 136) should be published on a quarterly basis as close to real time as possible and include new data on delays.
146. A national MHA data hub should be established to pull together and routinely analyse MHA data across NHS services, exploring possibilities for developing linkages across the various datasets, local authorities and policing.
147. The NHS, Home Office / policing and local authorities should work towards standardising ethnicity categories. This could be extended to all public sector reports including ethnicity.

Digital enablers

148. NHS England should build on the work of the Mental Health Trust Global Digital Exemplars and other trusts to test, evaluate and roll-out a fully digitised, consistent approach to the MHA.
149. Work should be carried out to streamline activity undertaken between NHSE, NHSD, NHSI, CQC, Tribunals and providers, to include improved digitisation of notifications such as early discharge to avoid late cancellation of tribunal hearings.

Quality Improvement (QI)

150. NHS Improvement and NHS England should fund the establishment of a national Quality Improvement (QI) programme relating specifically to the Mental Health Act.
151. The role of the CQC in monitoring the use of the MHA should be extended to cover all organisations that commission or provide services under the Act with due consideration given to the roles of other national bodies.

Staffing

152. The factors that affect the timely availability of section 12-approved doctors and Approved Mental Health Practitioners (AMHPs) should be reviewed and addressed.
153. The government should consider introducing a minimum waiting time standard for the commencement of an MHA assessment.

Improving staff morale

- 154. NHS England and NHS Improvement should consider the implications of the evidence linking staff morale and patient experience in the context of detained patients, and take action accordingly.**

GLOSSARY

Key terms	Definition
Advance Choice Document	A written statement that sets down your preferences, wishes, beliefs and values regarding your future care.
Advocacy	Activity by an individual or a group providing support to express the views and wishes and to stand up for the rights of people with mental health illness
Approved mental health professional	An approved mental health professional is a person qualified and authorised by the local authority to undertake assessments under the mental health act and decide whether detention under the Act is appropriate
Attorney	A person (aged 18 or over) appointed under the Mental Capacity Act who has the legal right to make decisions on behalf of a person in relation to their welfare, property or affairs of a person
Capacity	The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack capacity to take a particular decision (e.g. to consent to treatment) because they cannot understand, retain, use or weigh the information relevant to the decision
Care Act 2014	An Act designed to improve people's independence and wellbeing. Local Authorities have a duty to assess people's wellbeing and care needs.
Care and Treatment Plan	A document that sets out what a patient needs, and how this will be provided whilst detained under the MHA. This should include how regard has been taken for the known wishes and preferences of the patient, the aims of the assessment and treatment during detention and any proposed timescales before improvement might be expected. The Care and Treatment Plan should have a statutory footing and is critical to ensure the new treatment detention criteria is met. If the Care and Treatment Plan will be considered by the Tribunal as part of any review of a detention.
Care Programme Approach	A care planning system used mainly with people in England who receive specialist mental health care services. Involves an assessment, care plan and a care coordinator to oversee it. People who use care should be involved in their care.
Children's Act 1989	An Act relating to children and young people and those with parental responsibility for them
Code of Practice	Shows professionals how to carry out their roles and

Key terms	Definition
	responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005
Coercive Reward	Rewarding a patient to cooperate with mental health or other professionals involved with their care
Community Treatment Order	Can be used when someone is discharged from detention in a hospital under the Mental Health Act to ensure they undergo supervised community treatment.
Compulsory admission or treatment	Admission or treatment for mental disorder given under the Mental Health Act, which may be against the wishes of the patient
Convention on Rights of Persons with Disabilities	Protects the rights and dignity of persons with disabilities
Coproduction	As defined in the Care Act - when you as an individual influence the support and services you receive, or when groups of people get together to influence the way that services are designed, commissioned and delivered.
Court of Protection	The specialist court set up under the Mental Capacity Act 2005 to deal with issues relating to people who lack capacity
Court Appointed Deputy	A court appointed person who legally takes care of health, wellbeing and finance for someone with health problems. Also referred to as deputyship
Discharge	Unless otherwise stated, a decision that a patient should no longer be subject to detention, Community Treatment Order, guardianship, or conditional discharge
Dignity	The right to be valued and respected and treated ethically
Deprivation of liberty	Depriving a person of their freedom to act in the way they choose, usually in a care home or hospital after completion of a statutory assessment process, which includes an assessment that the detention is in the best interests of the person
Deprivation of Liberty Safeguards	An authorisation under the Mental Capacity Act 2005 given by a 'supervisory body' (a local authority or, in certain circumstances, the Welsh Ministers) which authorises a deprivation of liberty in a care home or hospital after completion of the statutory assessment process
European Convention on Human Rights	The European Convention for the Protection of Human Rights and Fundamental Freedoms. The substantive rights it guarantees are largely incorporated into UK law by the Human Rights Act 1998

Key terms	Definition
Human Rights	Substantive rights set out in the European Convention on Human Rights
Independent Mental Health Advocate	An advocate able to offer help to patients who lack capacity under the Mental Capacity Act 2005
Informal admission	Admission of someone who is being admitted for a mental disorder and who is not detained under the Mental Health Act
Joint crisis plan	A plan to support people during future periods of mental health crisis
Liberty Protection Safeguards	The new process introduced by the Mental Capacity Act (Amendment) Bill to replace the Deprivation of Liberty Safeguards (see above)
Mental disorder	An illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia
Mental Capacity Act	The Mental Capacity Act 2005. An Act of Parliament that governs decision-making on behalf of people, aged 16 years and over, who lack capacity, both where they lose capacity at some point in their lives, for example as a result of dementia or brain injury, and where the incapacitating condition has been present since birth
Mental Health Act 2007	Made several key changes to MHA 1983, laying down provision for the compulsory detention and treatment of people with mental health problems
Part 3 of the MHA	Part 3 of Act, known as the 'Forensic Sections', deals with patients who have been involved in criminal proceedings.
Pain-based restraint	A type of restrictive intervention which refers to any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person when pain is involved
Protected characteristics	It is against the law to discriminate against someone because of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. These are called protected characteristics.
Renewals	The process by which the period of detention under a section of the mental health act is renewed
Respect	Due regard for the feelings, wishes, or rights of others
Responsible Clinician	The Responsible Clinician has overall responsibility for care and treatment for service users being assessed and treated under the

Key terms	Definition
	Mental Health Act
Restraint	A type of restrictive intervention which refers to any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person
Restricted patients	Patients who, following criminal proceedings, are made subject to a restriction order where it appears that it is necessary to protect the public from serious harm
Safeguards	The presence of specific measures within the MHA 1983 that provide an important protective counterbalance to the extensive powers that are inherent in the Act.
Second Opinion Appointed Doctor	The SOAD service safeguards the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are deemed incapable of consenting. The role of the SOAD is to decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient.
Section 2	Assessment, patients can be kept in hospital for up to 28 days to allow for medical assessment. An approved mental health professional (AMHP) needs to apply to hospital. Patients have the right to appeal to a tribunal within 14 days, to appeal to hospital managers and to see an IMHA
Section 3	Treatment under section 3, patients can be detained in hospital for treatment for up to 6 months. An AMHP needs to apply to the hospital. Doctors may renew for 6 months then 12 months and patients appeals are allowed every 6 months
Section 117	Health, social care and support services in the community following discharge from hospital and to avoid future admission; especially the duty of the responsible health services and local authority to provide after-care under section 117 of the Act, following the discharge of a patient from detention for treatment under the Act.
Section 135	Warrant enabling a police officer to enter premises to either: remove a person to a place of safety to make an application under part 2 or other arrangements for their care or treatment or take (retake) into custody someone liable to be detained under the Act
Section 136	An emergency power which allows patients to be taken to a place of safety from a public place if a police officer considers that a person is suffering from mental illness in need of immediate care
Seclusion	Seclusion refers to the supervised containment and isolation of a patient, to contain behaviour that threatens harm to others
Tribunal	The First Tier Tribunal is an independent panel that can discharge

Key terms	Definition
	you from the Mental Health Act. The tribunal hearings take place at the hospital. The tribunal has to decide if you meet the criteria for being sectioned. Tribunals have the power to: discharge you from your section, recommend that you get leave, recommend supervised community treatment instead of staying in hospital, decide on a delayed discharge or conditional discharge, transfer you to another hospital, or meet up again if their recommendations are not followed.

ACRONYMS

Acronym	Meaning
AC	Approved Clinician
ACD	Advance Choice Document
AMHP	Approved Mental Health Professional
BAME	Black, Asian and Minority Ethnic
CCG	Clinical Commissioning Group
CJA	Coroners and Justice Act 2009
CPA	Care Programme Approach
CQC	Care Quality Commission
CRPD	Convention on the Rights of Persons with Disabilities
CTO	Community Treatment Order
CTP	Care and Treatment Plan
DoLS	Deprivation of Liberty Safeguards
DSPD	Dangerous and Severe Personality Disorder
ECHR	European Convention on Human Rights
ECT	Electroconvulsive Therapy
EHRC	Equality and Human Rights Commission
IMHA	Independent Mental Health Advocate
LGBTQ+	Lesbian, Gay, Bisexual, Transgender and Queer (or questioning) and others
LPS	Liberty Protection Safeguards
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983 (unless otherwise specified)
MHT	Mental Health Tribunal
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
OCF	Organisational Competence Framework
PCREF	Patient and Carer Race Equality Framework
RC	Responsible Clinician
SCP	Statutory Care Plan
SOAD	Second Opinion Appointed Doctor
SPA	Supporting Professional Activities
STP	Sustainability and Transformation Partnership
UKNPM	UK National Preventive Mechanism