

Modernising the Mental Health Act

Increasing choice, reducing compulsion

Final report of the Independent Review of the Mental Health Act 1983

December 2018

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FOREWORD - REVIEW CHAIR

It has been an honour to Chair this Independent Review of the Mental Health Act. But it has been more than that - a great responsibility and a profoundly moving experience. I have learnt much as the Review progressed, as well as having the opportunity to meet a remarkable range of people. The result is an extraordinary piece of collaboration, across a range of disciplines, putting into the practice the principles of co-production with patients and service users, which some outside observers have described as a model for future independent reports requested by government. But what follows is a single voice - my personal view on the background to the Review and some of the issues that shaped my thinking as the year progressed. Should you wish to hear from me again, I will also sum up what this means and pay tribute to all of those who have made this possible in a brief afterword.

For those of you who have opened this document to find out what we have recommended, my first recommendation is to skip this introduction and move straight to the next section.

Why do we have Mental Health Acts?

On the one hand, the Mental Health Act takes away your liberty and imposes treatment that you don't want. It can be traumatic, frightening and confusing. But on the other it can help restore health, and even be life-saving. It is an imposition on personal freedom, but it can also help people to become freer from the pain and distress that accompanies the most severe of mental illnesses.

This paradox or tension is nothing new. Society and State have been debating for two centuries or more how to balance an individual's right to autonomy with the desire of a civilised society to protect its most vulnerable. Our cultural and ethical traditions support the concept of autonomy. Allowing everyone to make the decisions that affect their life and accept the consequences of those decisions is a key aspect of respecting the unique value and character of each human person. And in recent years it has become clearer that there is no reason why that should be rescinded simply because an individual is unwell.

But our cultural and ethical traditions also support the concept of protecting the vulnerable and those unable to care for themselves. The desire to help a fellow human being in serious distress is one of the more attractive aspects of human nature – and societies seek to encourage this by encouraging charitable actions in giving, respecting those in the "helping professions", or giving legal protection to "Good Samaritans". Moreover, most health professionals (and indeed judges) possess well-developed protective instincts. And most of us, if we see someone about to jump from a bridge, would try to help them step away.

Few would like to live in a society in which an individual has precious little autonomy. But nor would we like to live in one that does little or nothing to protect its most vulnerable. And if individuals are ever truly free to choose, which some doubt, they are far less so when they are, in the words of Nikolas Rose, a leading sociologist and critical commentator, “in states of anguish, despair or tormented by voices telling them they are worthless and should die” ¹.

These two strands cannot always live together: choices have to be made. This tension often explains the differing perspective of patients (who understandably put a high value on autonomy) and people like me, professionals in the field of mental health, who made that choice because they believed, with some justification, that they had something to offer to people in such distress - a "treatment" in the broadest sense of the word, be it physical, social or psychological. I grew up thinking that some temporary intrusion on autonomy is a proportional response to an acute or desperate situation, and that this was often best done in a hospital setting. To quote Nikolas Rose again:

“sometimes compulsory admission to a place of safety for a short period of respite care, even where conditions are far from ideal, together with the short term, even involuntary, administration of some sedative medication, can be a way of returning an individual in such a state of extreme distress to a condition where they can make thoughtful decisions about their own lives”. (Rose, 2019, p175)

But it is far from ideal. As Rose continues:

“Of course all too often the institutions in question do not provide safety, respite and care, and the administration of medication is excessive, prolonged and for the benefit of staff rather than patients²” (Rose, 2019, p222)

During the year I encountered many people and many settings which did not conform to Rose’s image, but the experiences of too many service users convinced me that he has a valid point. I heard compelling narratives that for some detention left them worse, not better off. Of course all interventions, and being detained under the Mental Health Act

¹ Nikolas Rose; Our Psychiatric Future. Polity Press, 2019

² A quick word on nomenclature. What do we call those who have mental health problems (it is impossible to even describe the problem without selecting some phrase that will inevitably be criticised by someone) or who use mental health services? Some prefer “people with psychosocial disabilities”, but not everyone with mental health problems consider themselves disabled. So I will use patients as in the word "inpatients", but service users for the wider context

(MHA) is an intervention, have side effects. The treatment that only does good, and never harm, doesn't exist. But we can only help reduce these outcomes if we accept they happen. I often heard from those who told me, looking back, that they realise that compulsory treatment was necessary, even life-saving, but then went on to say "why did it need to be given in the way it was?". And it was that last comment which has given rise to the majority of our recommendations.

So like Rose, I continue to believe that it is at times reasonable to make a temporary infringement of liberty and autonomy, and even impose treatment on people who do not want it. But we have to do better in ensuring that no one is made worse than they would have been without this imposition, more are made better, and all have their dignity respected. Likewise, as far as possible they should still be able to make choices as to how they are treated.

Fear

In the various conversations that I have had with patients, service users, carers, and professionals of every description, one thing that was never far from the surface was fear. The public are often fearful of mental illness and of the consequences which they have been led to believe flow from it, specifically the danger posed by people living with mental illness. Professionals are fearful that unless they adopt a cautious, risk averse approach to their patients, they will find themselves being publicly shamed for those occasions when those same people cause serious harm to themselves or others. Patients are often fearful not only of the consequences of such illness but of how they will be treated by society in general and the mental health system in particular. They do not always experience kindness, particularly where the state's powers of coercion have been invoked.

Risk aversion and its consequences

One of the things that I initially found baffling was how to explain the inexorable rise of detentions under the Mental Health Act, something that has been happening for many years. My academic discipline is epidemiology, the study of populations, and I knew that the rates of severe mental illness have not changed substantially over the period. In the report and reviews which follow, these matters are discussed in detail, and a number of factors identified as contributing. But there is another issue, difficult to pin down in statistics, but which has played a substantial role in this rise, and contributes to some of the problems that we report in creating and sustaining a genuinely therapeutic atmosphere for those detained. It is the issue of risk and risk aversion

Some of this can be traced to the reasons which lay behind the introduction of the 2007 Act, a process that began nearly ten years earlier. Reading the newspapers, speeches,

discussion papers and documents from the time, the risk posed to the public by those with mental illness, and the failings of the mental health care system to adequately manage those risks, was the major driver of the perceived need for reform. And one can understand why. The killing of Jonathan Zito by Christopher Clunis had shocked everyone, as did the crimes committed by Michael Stone.

These fears have not gone away. My doctoral thesis back in the mists of time was titled “Crime and schizophrenia”, part of a body of evidence showing that although the risk of serious violence committed by those with severe mental illness is low, it is still slightly higher than the general population. There is a far greater risk of serious harm to self, but we cannot deny that there is also a risk to others, even if usually overstated by public, politicians and media. Sadly looking back we can see that some of the decisions taken by government leading up to the 2007 Act were an overreaction. There was the introduction of the concept of Dangerous and Severe Personality Disorders (DSPD). The initial optimism felt in some quarters has largely given way to disappointment as it became clear that most were just being detained for the protection of the public, and that better (and cheaper) alternatives were available³. A similar but not identical argument is raised now, with justification, for the fact that some people with a learning disability, autism or schizophrenia are being “warehoused” as we now call it in locked rehab wards, or unsuitable long stay wards which exacerbate and not ease their problems.

Another consequence was the introduction of Community Treatment Orders (CTOs), which continue to divide opinion, including that of this Review. However, there is a consensus that things need to change, and this is reflected in our report.

But there is good news. No one can fail to have noticed the change in public attitudes towards mental illness⁴. Now positive stories about mental illness outweigh negative ones. Media headlines are always a good barometer of the zeitgeist, and some of the stigmatising headlines of the past are much less common, if not entirely a thing of the past.

³ Tyrer P, et al. The success and failures of the DSPD experience: The Assessment and Management of Severe Personality Disorder”. *Medicine, Science and the law* 2010; 50: 95-99

⁴ Sara Evans-Lacko S., Corker E., Williams P., Henderson C., & Thornicroft G. (2014) Trends in mental-illness-related public stigma among the English population in 2003–13: effect of the Time to Change Henderson C, Robinson E, Evans-Lacko S, Corker E, Rebollo-Mesa I, Rose D, Thornicroft G. Public knowledge, attitudes, social distance and reported contact regarding people with mental illness 2009–2015. *Acta Psychiatr Scand* 2016; 134 (Suppl. 446): 23–33 DOI: 10.1111/acps.12607.

Corker E, Hamilton S, Robinson E, Cotney J, Pinfold V, Rose D, Thornicroft G, Henderson C. Viewpoint survey of mental health service users’ experiences of discrimination in England 2008–2014. *Acta Psychiatr Scand* 2016; 134 (Suppl. 446): 6–13. DOI: 10.1111/acps.12610.

Does this matter? Very much so. The rhetoric surrounding the genesis of this Review could hardly have been more different from that of 20 years ago. The Terms of Reference of this Review speak about the problems of the rising rate of coercion, seen as something undesirable, as opposed to the aim of public policy. Discrimination and stigma, especially towards ethnic minorities, is specifically included. Likewise, I was tasked to see if the Act is up to date in how it deals with human rights (it isn't). During the time of this Review, neither myself nor my three Vice Chairs have experienced any political pressure to shape our decisions in a particular direction. Last time it was Genevra Richardson who was given the same task as I have today – delivering a review to inform a forthcoming revision of the 1983 Mental Health Act. But apart from the coincidence of both having been asked to conduct such a review, our situations could scarcely have been more different, and I hope that she will feel that we are at last achieving some of the objectives that she wished for almost 20 years ago.

Fear and risk aversion

So whilst fear of the mentally ill has decreased in the public, parliament and media, a different kind of fear has increased - the fear of making a faulty risk assessment that influences many professionals.

The importance of risk management and safety has steadily risen across society – as reflected in some key sociological texts⁵. It is seen by many as a principal driver in modern society, so it is not surprising that it has become very influential in medicine as a whole, partly driven by scandal and perceived failings. But there are few places where it has achieved the prominence or dominance that it has in mental health, and this happened over a relatively short period of time. When I started my first post in psychiatry in 1984 risk assessment was taught to everyone in the context of deliberate self-harm, but in general it was forensic psychiatry that was most concerned with it, and where most of the relevant research originated. But within a few short years this had changed.

As Szmukler⁶ writes “a pressure developed affecting all levels of staff, managerial through to clinical, to 'manage risk', which was the intended consequence of this shift in policy. But this soon slipped into 'managing risk to themselves’”. And Szmukler continues, this is understandable, since the consequences of a faulty risk assessment were and continue to

⁵ Ulrich Beck, Risk Society. Sage, 1992.

⁶ Szmukler G, Men in White Coats: Treatment under Coercion. Oxford University Press, 2018

be “quite horrendous... protracted investigations and scrutiny of the case, blame, negative publicity, formal inquiries, and scores of recommendations requiring implementation”.

It is easy to see how this would have been reflected in a steadily rising number of detentions, as professionals of all kinds became increasingly risk averse, and more likely to make coercive interventions that at least in the short term were likely to reduce the risk of an early dreadful outcome – such as serious or fatal harm to a patient or a member of the public⁷.

Some of the consequences are obvious – namely the rising rate of detentions. Others are not so obvious, but can be seen in the myriad reports we have from service users of unnecessary restrictions imposed upon them, usually justified in the name of safety. We are not talking about appropriately mandatory measures such as ensuring the absence of ligature points, but others that seem at best exaggerated or disproportionate and at worst petty, accompanied by statements such as “you never know what might happen” and “we just can’t take the risk”. The outcome can be an increasingly sterile inpatient environment (see sections on inpatient physical and social environments). What I would like to see is a wider realisation that sometimes to reduce risk you need to take risks.

But we cannot act on our own. If we are seriously to tackle the problem of risk aversion action must proceed across the board – there is little point in professionals deciding to accept more risk if the courts, regulators, media and others do the opposite. Intellectually everyone accepts that there is no such thing as zero risk – even if you detained every person with any mental disorder for prolonged periods of time, an absurd proposition, you would still not eliminate it. Any probability judgement must be wrong sometimes, and that should not automatically mean that this is a fault, let alone negligence. But the dynamics of the risk society seem to be running in the opposite direction, accelerated by legal judgements such as the one handed down by the Supreme Court in the tragic case of Melanie Rabone⁸. As the President of the Supreme Court remarked recently, this judgement “where the hospital was held liable for the death of an informal patient who killed herself whilst on weekend leave of absence is bound to make practitioners less

⁷ My thanks to Sarah Markham for bringing this quote to my attention: “Sometimes I think we try to change somebody’s circumstances to deal with our own anxieties, rather than the concerns they have about themselves or the risks they actually present” (Norko, M., Baranoski, M. The prediction of violence; Detection of dangerousness. Brief Treatment and Crisis Intervention, 2008; 8, 73–91)

⁸ <https://www.supremecourt.uk/cases/docs/uksc-2010-0140-judgment.pdf>

inclined to use informal care". In other words to increase, not decrease, the usage of the MHA.⁹

Patient fears

As I mentioned earlier, I heard many stories from service users that detention not only had little beneficial effect, but left some worse, and not better, off. For some detention had a negative impact on family life, children, employment or housing. The circumstances of detention, especially if accompanied by the use of physical restraint, even caused long term psychological scars. A central theme of this Review is how we can do better to reduce such outcomes, and preserve, as opposed to imperil a person's dignity. But such stories were strongest in those from ethnic minority backgrounds. As one person told me "for a black person, a psychiatric hospital is seen as the place where they drug you up, and at worst even kill you".

Ethnicity, Racism, and Discrimination

When I started my career in psychiatry research, one of my earliest papers back in 1989 was on the subject of the over representation of those of black African and Caribbean heritage amongst those diagnosed with schizophrenia. Not surprisingly this excess was also seen, to an even greater extent, in those detained under the Mental Health Act. Now, 30 years later, it is sad to record that little has changed. There does appear to be more consensus that this increase is real, and not an artefact, and also that it is related to experiences of discrimination, exclusion and racism. There is also consensus that even taking this into account, the use of coercion is far greater in this population, finding its most painful expression in the statistic that those of black African or Caribbean heritage are over eight times more likely to be subjected to Community Treatment Orders than those of white heritage¹⁰. In other words, too often and in too many areas the experiences of those of black African and Caribbean heritage is one of either being excluded or detained.

So we have to accept the painful reality of the impact of that combination of unconscious bias, structural and institutional racism, which is visible across society, also applies in

⁹ Speech by Lady Hale of Richmond, International Congress of the Royal College of Psychiatrists, Birmingham, Sunday June 24th 2018.

¹⁰ <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2017-18-annual-figures>

mental health care. I know that many people will be made to feel uncomfortable by these terms; and indeed I was one of them.

I believe that those motivated to go into a career in mental health rarely do so out of desire to make lots of money (there are easier ways). I would like to believe that they are more likely to have attitudes and experiences that ought to make race thinking¹¹ and stereotyping less likely. But I have come to accept that this is not always true. Even though my respect and admiration for my fellow professionals persists, I recognise that no one is completely free from biases, and all of us can have feet of clay. But our Review does not wish to point fingers. Instead we need to acknowledge and take responsibility for past failings, and the manifest inequalities in our mental health system, and in this report we do just that. Having taken responsibility, we need clear steps to reduce the disparity in outcomes, supporting behaviour change at every level. Then we can work together to address this, in the knowledge that much of what is needed must occur across society. I hope that our proposals, initiated, shaped and led by those of black African and Caribbean heritage, alongside the recommendations that emerged from our group considering other ethnicities, go some way to addressing a long standing situation that does us little credit.

Towards a rights-based Mental Health Act

One of the Terms of Reference for the Review was to assess if we were up to date in recent developments regarding the rights of those with mental illness. We aren't. The last revision of the Act in England and Wales took place in a climate which was far from ideal to make the changes that even then many wanted to see. But we have moved on.

I have already laid out the case why there is no simple solution to the issue of autonomy versus protection, which no amount of legislation, recommendations, reports or inquiries can solve. The same goes for human rights. How does one balance competing rights? The European Convention on Human Rights (ECHR), part of UK law, places great import on protecting the life of vulnerable people, as it should, and the Court has supported involuntary detention for this purpose. But this cuts across Article 5 rights relating to liberty and security of person. And so on.

But if even judges find it difficult to balance competing rights, there is no danger of contradictions when it comes to the necessity of rebalancing the system to be more

¹¹ Arendt, H. (1944). Race-Thinking Before Racism. *The Review of Politics*, 6(1), 36-73. doi:10.1017/S0034670500002783

responsive to the wishes and preferences of the patient, to take more account of a person's rights, and to improve the ability of patients to make choices even when their own circumstances make this far from easy.

Our recommendations cover a number of areas, but if I was asked to name the most important theme it would be this - patients must be supported to make more choices for themselves. This links our proposals on advance directives, nearest relatives, access to advocacy, better safeguards and a new right of appeal against compulsory treatment. I was surprised by the number of service users and former patients who have told me that their issues were not so much with being detained, although that is an issue, but the way in which having been deprived of their liberty, they were often deprived of much else. In other words, their wishes, preferences and choices were often not respected.

So we intend to shift the balance of power between patients and professionals. To make it easier for a patient's wishes to be respected both in the present and the future, in anticipation of the sad reality that many patients who have had one compulsory admission are likely to be faced with another. I believe that our proposals will lead to a culture change with our inpatient services, that the default position will be to respect such choices, rather than reject them. However, this will not be absolute. A career in medicine, let alone psychiatry, has convinced me that that in real life things are rarely so clear-cut that one can use the word "never". There are still situations where this will not be advisable, such as emergencies and the preservation of life. Nor can any professional be forced to follow a course of action that they believe to be ineffective or harmful.

I am confident that our recommendations will "shift the dial", in favour of greater respect for wishes, choices and preferences. And I am confident that this has the support of all the stakeholders we have consulted. Research across the board, not just in mental health, has established beyond doubt that the greater the involvement of patients in decisions about their care and treatment, the better the outcome. I believe that these changes will increase a person's dignity, reduce the likelihood of unintended adverse outcomes, and reduce the risk of subsequent relapse. It will also go some way to overcoming the negative views that exist around inpatient psychiatric treatment.

Few will disagree with any of this. But some will point out that we have not gone as far as to recommend fully implementing the UN Convention on Rights of Persons with Disabilities (CRPD), or to be precise, how that is interpreted by the Committee charged with its implementation. And they are right. We haven't. For example, the Committee's recommendations would include not just dropping the MHA, it was also require us to end all forms of substituted decision making, which would have to include for example dropping the Mental Capacity Act as well. I agree that the Mental Capacity Act (MCA), or more specifically the Deprivation of Liberty Safeguards (DOLS), needs urgent reform, which is happening as we speak. But the idea that those who lack capacity to take decisions for themselves should have no protections, save supported decision making, against

exploitation, excessive detention and so on, seems to me to be something that most people and Parliament will find difficult. I do not think that we are compelled to follow this interpretation, and we will not.

But focusing solely on what we are not advocating would be to mask the common ground that we share, and, in particular, the need to take what Dainius Puras calls the “deliberate, targeted and concrete”¹² actions to eliminate human rights violations within mental health settings. I am confident that we have set out legal measures to address such violations. But during the course of the Review I have learned from many wise people that legislation is a rather more blunt instrument than I had naively believed, is rarely effective on its own, and works best alongside practical measures – in this case to reduce both the place for and the need for coercion, the central concern of the CRPD committee in this context.

What that means is that there are many steps that can be taken that do not require legislation to ensure detention is truly a last resort¹³, foremost among which is providing more and better alternatives, including those developed with and by service users. As I write we wait for the details of the NHS Long Term Plan, which I hope will include a significant boost for our hard-pressed community and crisis services, plus recognition of the importance of local smaller initiatives that we champion in the report, particular when created by those from ethnic minority communities.

These don't require legislation, and neither does giving greater prominence to the choices and preferences of those detained, but frankly, that has been the case for years, and yet no progress has been made. So legislation is a necessary “back stop” to ensure that cultural change really does occur, to nudge people to do the right thing, and put in place robust safeguards when they don't. Hence our recommendations on new rights to challenge treatment decisions, or to ensure people's advance decisions have real legal protection. Implementing our proposals will go a substantial part of the way to addressing the concerns motivating the CRPD Committee. But in rejecting the last steps that they propose - the abolition of all mental health legislation, whether a Mental Health or Mental Capacity Act, I wish to be clear. It is true that we do not currently have the legislative space that would be required for such a radical step. But to use this as a reason would be

¹² Dainius Pūras, “Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (2017) A/HRC/35/21, para 66.

¹³ I am sure most people would agree with that statement. There is also a well reasoned view that hospital admission, whether coerced or not, should never happen at all. I am less convinced by that, and believe that there is still a place for brief asylum, and a case that earlier admission may avoid a later compulsory one. During the course of the review I resisted the temptation to call for more hospital beds as some wished, but neither would we call for fewer (a view also held by many) The former was also unlikely to be heeded in the current economic uncertainty, the latter probably unwise, except perhaps for those areas which had not yet fully caught up with the deinstitutionalisation programme in general psychiatry.

disingenuous. The reason is simpler – I don't agree with it, and I am far from sure that is what most service users want either, as well as many others¹⁴.

The rise and possible fall of informality

Over the last decade, legal procedures, either under the MHA or MCA, have come to dominate hospital admissions, and it is increasingly difficult to be a voluntary patient. On first impression, this seems to be putting the clock back. The 1845 Lunacy Act introduced a legal process for detaining 'pauper lunatics' through the agreement of a local magistrate and a doctor. The doctor affirmed that the patient was "a lunatic, idiot or insane person, or a person of unsound mind", and then the magistrate issued an order which allowed confinement. The 1890 Lunacy Act tightened the process and mandated two separate medical certificates. The idea of a voluntary patient was not introduced until the 1930 Mental Treatment Act, which also facilitated outpatient treatment. Like so much else in British society, these changes were inspired by the legacy of the First World War. The spirit of the 1930 Act was continued in 1959, with patients now able to be admitted to any hospital without formalities of any kind. But since then we have seen a steady rise in formal admissions, first under the MHA, and now in greater numbers under the Mental Capacity Act via the Deprivation of Liberty Safeguards (DOLS). If the current increase continues, the person who is truly voluntary, admitted without any legal paperwork, will become a rarity. In a time when we talk about "parity of esteem", the contrast with what happens in our acute physical health sector is striking. In this Review we discuss the situation, but I am afraid, to paraphrase H.H. Munro (Saki), one of our great short story writers, killed in 1916 – "If we point a problem at least we suggest no remedy". I suspect it is inescapable now we live in a society where trust in professionalism is a steadily decreasing commodity, and we prefer regulation and the law as safeguards and protections.

¹⁴ Reversing hard won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities. Freeman M et al. *Lancet Psychiatry* 2015; 2: 844-850

Severe mental illness has been overlooked - it's now 'Time to Change' that

Great things have indeed happened in our world, with an extraordinary growth of interest in mental health. The campaigns led by organisations such as Time to Change or Heads Together have changed the way we think and speak about it. Sustained investment in programmes such as Improving Access to Psychological Therapies has had major impact on the management of the common mental disorders, chiefly anxiety and depression. But none of this has made much impact on those with most severe mental illnesses. The situation has been rightly described as a “burning injustice”, and needs to change. We need investment in alternatives to detention, a reinvigoration of our community services focussing on a much broader and swifter offer of alternatives to compulsory treatment. And when this is still regrettably necessary, we must acknowledge that the environment in which we look after those detained under the Act is now often anything but therapeutic. Those parts of the estate that remain following the extraordinary period of change that saw the end of the asylums – psychiatry being the only discipline that has transformed from being almost entirely hospital based to being almost entirely community based - are showing signs of age, and can be a major obstacle to the delivery of therapeutic care. Frankly, I am not surprised that many people are reluctant to be admitted to some of our facilities.

Changing much of the above does not depend on the MHA. But hot on the heels of this report will be the NHS Long Term Plan. I am hopeful that at least some of the above will not be overlooked, and we may be welcoming the start of the kind of transformation that created the talking therapies programme. Whatever happens, our report must be read in conjunction with the NHS Long Term Plan.

And now read on

So now it is on to business. In what follows you will find our recommendations. Throughout we have been guided by the principle that we want the Mental Health Act to work better for patients, the public and professionals. We hope that the result will be to reduce the use of coercion across the system, whilst giving service users more choice, more control and better care, even in the event that detention is still required. And we particularly hope that the end result will be to reduce the inequalities and discrimination that still remain.

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 foundation¹⁵, 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.

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 Independent Mental Health Advocate (IMHA) or informally through a friend, family member, or the Nominated

¹⁵ https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps01_18.pdf?sfvrsn=53b60962_4

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 (UNCPRD). 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 Duty¹⁶, 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

¹⁶ 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

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.

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 impacts, 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 circumstance 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

LETTER FROM THE REVIEW'S SERVICE USER AND CARER GROUP

Dear Prime Minister,

We are a group of thirteen individuals who have either previously been detained under the Mental Health Act or have cared for someone who has. Throughout the process of this Review we have sought to provide a voice to the realities of life under the Act. Our lived experiences range from informal treatment, through many different sections of the Act, as well as across community, inpatient and forensic settings. Members have also represented the experiences of young people, individuals with learning disability and autism, and those who have died whilst under the Act. We represent a diverse range of ages, genders, and ethnicities from across the country.

We were tasked with ensuring that individuals detained under the Act are “treated with dignity, and that their liberty and autonomy is respected as far as possible”. Chaired by a Vice Chair of the review, we placed service user views at the heart of the entire process, were consulted throughout, and members were involved in eighteen topic groups that looked closely at vital, complex issues.

Many people under detention feel that they are unheard and powerless to change things. As service users and carers we feel a strong sense of responsibility to those people, often the most vulnerable, to make their experience better. As things stand, the treatment received during detention can be in many respects worse than the fact of detention itself.

In this letter, we outline our support for the report, highlighting some specific areas that we have championed and where we believe, if implemented, will make a tangible and substantial difference to those who interact with the Act. We welcome the set of four principles outlined in this report; an ethos for what the experience of detention should be.

Principle 1. Choice and Autonomy

We wholeheartedly endorse the move towards empowering service users to have a greater say in their care and treatment. The current lack of flexibility and choice in the components of one’s treatment is oppressive. The proposed power to nominate the person they want to have special rights and the ability to make advance choices about treatments could be game changers. With appropriate safeguards in place, such changes would ensure that the wishes and preferences of service users are considered, even if they lose capacity.

As a group we have advocated strongly for greater transparency in clinical decision making and better responsiveness to patients' own opinions on their care and treatment. We are therefore delighted to see the recommendation that the service user's voice must be recorded and validated in the statutory Care and Treatment Plan. This move to mandatory recording of shared decision making gives greater voice to service users and carers who often have great understanding, knowledge and experience of what best supports the service user's wellbeing and recovery. Not only does this promote patient dignity, we strongly believe that taking our views into consideration will contribute to better outcomes.

Finally, we welcome the coordinated changes to tribunals, SOADs, advocacy and hospital visitor roles which would provide service users and carers with more accessible and timely opportunities for questioning when there are concerns about their care and treatment.

Principle 2: The use of Least Restriction

We welcome a recognition that care should be delivered safely in the least restrictive way. Too often, there are constant, and often disproportionate, restrictions on all aspects of a person's life, which have negative consequences. We feel strongly that care should focus on embedding proactive measures to avoid escalation, as opposed to reactive ones that require de-escalation. Least restriction starts with the therapeutic environment; involving service users as partners in care planning builds the relationships that reduce the need for restrictive interventions. Further advancing this principle is the message that criminal justice settings are not appropriate for people experiencing mental health crisis, reflected in our proposals to end or further reduce the degrading use of police cells, police vehicles, and prison cells.

Principle 3: Therapeutic Benefit

We are united in our belief that if people are to be detained then it is vital that the detention should be of therapeutic benefit. This should not be limited to any treatment they receive but must also cover the social and physical environment of wards. We are happy to see that the Review is recommending a statutory right to a Care and Treatment plan, which would support continuity of care before, during and after detention. This should ensure people get a higher quality after-care plan which addresses their needs. We are also encouraged that the Review has a focus on improving the ward culture to support dignity, safety, and recovery, and ward environments that better enable the delivery of therapeutic care.

Principle 4: The Person as an Individual

Among the service users in our group, we include holders of PhDs, medical professionals, artists, a published poet, trustees for charities, volunteers, (disability) activists, as well as exercise enthusiasts. Some of us have experienced trauma and abuse. We are individuals with a diverse range of abilities, skills and expertise and we endorse the emphasis on the importance of considering this. The need for respect and regard for such aspects of our personalities and identities is arguably never as important as when we may be in a crisis, feeling at our most vulnerable, and experiencing a system which has the power to deprive us of our freedom.

We welcome the recommendations for children and young people, those with learning disabilities and/or autism, and the strong focus on addressing the disproportionate outcomes for people from ethnic minority communities and in particular black African Caribbean men. In particular, we are pleased to see endorsement of guidance that protects against the overuse of medication for individuals with learning disabilities and/or autism, and the Community Needs-based Organisational Framework, which emphasises the importance of understanding and providing for the needs of local communities.

Several themes continued to re-emerge in our discussions over the course of the Review, which we feel underpin many of the negative experiences of service users and carers of the Act. Many people find that their experience and knowledge are overlooked and that their views are rebuffed and mis-labelled as 'lack of insight' and/or 'an aspect of your disorder'. We believe patients, families and carers must be treated with a presumption of credibility and be a core participant of all decisions made regarding the patient's welfare. Secondly, we want to acknowledge the adverse consequences of the detention system. Vulnerable, powerless, in a locked ward; being a patient under the Act is unlike any other provision of health care. When it works at its best the Act provides an opportunity for a person to get the care they need. At its worst it leads to harm and additional difficulties, over and above that which led to admission, and as such, serves only to perpetuate the cycle of detention. We hope that progress in these areas will be a component of the culture change which the proposed principles and recommendations seek to realise. Finally, the importance of carers should not be overlooked. Carers are often essential in the recovery process and need sufficient information and support themselves.

As individuals within a collective, we all have different experiences of the Act. Naturally this means we have different views on what we feel are the most important areas for reform. In some cases members have felt that certain recommendations could have gone further and created the potential for even greater positive impact. For some reforms there is a difference of opinion, and no one person will agree with the entirety of the recommendations. This being said, we have all worked together tirelessly to produce a document which reflects the views of both service users and carers. When looked at as a package for reform we feel that, were the recommendations to be adopted, the Act would

work better for service users, for families, carers and professionals by delivering better experiences, and better outcomes.

We call upon the Government to accept all the recommendations contained within this report.

Steve Gilbert and the Service User and Carer Group

HOW THE REVIEW CARRIED OUT ITS WORK

We sought input from a broad range of people, organisations and evidence sources over the course of the Review. This section summarises the work we undertook to understand the breadth of people's views and the evidence available when making our final recommendations.

Hearing from people affected by the Mental Health Act

First and foremost, we were conscious to hear from people with direct experience of the Mental Health Act, as well as those who support them and the organisations that seek to represent their views. We also invited input from professionals and organisations that use the Mental Health Act, such as those within the health, social care, legal, voluntary and community sectors.

Specifically, we:

- Worked with organisations across the country to run over 50 focus groups with service users and carers. These groups facilitated discussions on issues affecting a wide range of groups (such as people from ethnic minority communities and people with learning disabilities, autism or both) as well as different interactions with the Mental Health Act. Accessible formatted materials were provided to support these discussions. Focus groups first took place ahead of our interim report, which set our priorities for further investigation. A second set of focus groups tested the Review's emerging proposals. A report of these focus groups will be published soon.
- Launched a dedicated survey of service users and carers to learn about people's experiences of, and attitudes to, detention under the Mental Health Act. We received over 1,500 responses. We analysed the results to identify key themes and issues for further investigation, a copy of our summary is annexed.
- Hosted seven free, public workshops in Cardiff, Exeter, Liverpool, London and Newcastle in spring, summer and autumn 2018, which were attended by a broad mix of service users, carers and professionals. The objectives of these workshops mirrored those of the focus groups. The discussion content of two of the workshops was live tweeted, enabling interested individuals to follow the discussion and provide their comments online. A report of these workshops will be published soon.

- Hosted bespoke roundtables on priority areas, including the experiences of black African and Caribbean individuals, and the interaction between the Mental Health Act and Mental Capacity Act (and the potential for fusion law).
- Sought evidence submissions from organisations and professionals on practical issues of implementation and workability of the Mental Health Act as it stands, as well as suggestions for improvements.

In addition, we attended meetings and events related to the work of the Review hosted by a wide range of stakeholder organisations. We also visited to services across the country to witness first-hand the Mental Health Act in action. We are grateful to the following for hosting us:

- The Cellar Trust, Bradford
- The Integrated Acute Care Hub, Bradford
- Leeds Survivor Led Crisis Service (LSLCS), Leeds
- Look Ahead, London
- MayTree Suicide Respite Centre, London
- MIND, Bradford
- North East London NHS Foundation Trust (NELFT), London
- Touchstone Crisis Café, Leeds

Governance and topic groups

The Review has been supported throughout by four governance groups: the Working Group; the Service User and Carer Group; the Advisory Panel; and the African and Caribbean Group (MHARAC). Terms of reference for these groups are available on our webpage.¹⁷ We also established eighteen Topic Groups in the second phase of the Review to develop policy proposals.

¹⁷ <https://www.gov.uk/government/groups/independent-review-of-the-mental-health-act>

Working Group

The working group supported the Review's chair and vice-chairs to develop their recommendations and reports. Members provided expert advice, working to ensure the Review's outputs are founded on the available evidence, and reflect the contributions of a range of personal experiences, professions and organisations. The working group comprised individuals with a range of experience relevant to the Mental Health Act and its application.

Service User and Carer Group

The Service User and Carer Group was made up of individuals who were or had previously been detained under the Mental Health Act, or had experience caring for an individual who had been. The group's members provided perspectives on the Mental Health Act acquired through personal lived experience and reflections on the experiences of other service users and carers gained through experiential learning. The group considered issues with the Mental Health Act, and played a critical role to identify solutions. A letter from the group is included in this report.

Advisory Panel

The advisory panel brought together a range of experts by either personal ('lived') or professional experience with an interest in the Mental Health Act and its application. The panel served as a forum for gathering evidence and insight throughout the course of the Review, helping to shape the final recommendations. The panel comprised individuals with lived experience, advocacy organisations, professionals, representative bodies, and representatives from the statutory sector.

African and Caribbean Group (MHARAC)

The Mental Health Act Review African and Caribbean group (MHARAC) was established to support one of the core aims of the Review: to understand the reasons behind the disproportionate number of people from ethnic minority groups detained under the Mental Health Act, and to identify ways to make the Act work better. MHARAC led work to develop the recommendations in the final report designed to ensure that people of black African and Caribbean descent with mental health challenges receive the treatment and support they need. The group's report to the Review leadership will be published shortly.

Topic groups

In the second phase of the Review we established eighteen topic groups to explore in further detail the priority areas identified in the Review's interim report. Each group comprised a small group of experts, including those with lived experience of the Mental Health Act and professionals. The groups' reports informed thinking in the final phase of the Review, as the final recommendations to government were finalised. These reports will be published shortly.

Evidence commissions: research and data

In addition to our consultation work, we spent time assessing existing evidence and data in relation to the Mental Health Act, and commissioned bespoke data analysis to inform our findings.

Research commissioned throughout the course of the Review included:

- A review of **rates of detention across over 20 higher income countries**, identifying trends in compulsory admission rates (since 2008) and characteristics of countries' legislative systems regarding compulsory admission.
- A systematic review of **clinical and social predictors of compulsory admission**, which could provide a broader overview of at-risk groups and potential determinants of detention
- A systematic review of **advance statements and crisis plans**, determining any link with the rate of compulsory admissions.
- A systematic review to explore the clinical effectiveness of **Community Treatment Orders**.¹⁸
- A scoping review of all **interventions to reduce compulsory admissions**.
- A systematic review of **service users and carers' experience** of compulsory admission.

¹⁸ Barnett, P., Matthews, H., Lloyd-Evans, B., Mackay, E., Pilling, S., & Johnson, S. (2018). Compulsory community treatment to reduce readmission to hospital and increase engagement with community care in people with mental illness: A systematic review and meta-analysis. *Lancet Psychiatry*, 5: 1013–22

- A rapid systematic review to explore the experiences of services users, family members, carers and professionals of the use of the **'nearest relative' provisions** in the compulsory detention and ongoing care of people under the Mental Health Act.¹⁹
- A qualitative exploration of the **perspectives of people of black African and Caribbean descent** on the Mental Health Act.

Summaries of these papers are annexed to this report. In addition, bespoke data analysis included:

- Analysis of patient-level data at South London and Maudsley NHS Foundation Trust and Camden and Islington NHS Foundation Trust to explore issues such as: variation in detention rates (by age, gender, ethnicity); detention and re-detention rates; changes in length of stay over time; and a comparison of informal and formal admissions over time. Trends identified in each provider will be compared.
- Further interrogation of the Mental Health Act Statistics 2016-17 by NHS Digital, to explore: the number of detentions and re-detentions by characteristics (age, gender and ethnicity); and the number of detentions following use of section 136 by ethnic group.
- Data from HM Courts & Tribunals Service on the success rate of tribunal appeals by section type.
- Data from Her Majesty's Prison and Probation Service on transfers, discharge, recall and leave for restricted patients.

Our engagement in numbers:

Over 50 focus groups with service users and carers

Over 1,500 survey responses from service users and carers

Seven regional workshops with a total of over 550 attendees

¹⁹ Shaw, ED, Nunns, MP, Briscoe S, et al. (2018) Experiences of the 'Nearest Relative' provisions in the compulsory detention of people under the Mental Health Act: rapid systematic review. Health Services and Delivery Research. <https://ore.exeter.ac.uk/repository/handle/10871/34260>

Over 150 responses from professionals and organisations to our call for evidence

18 topic groups

Over 15 bespoke research and data commissions

We would like to acknowledge the significant input of all people who contributed their thoughts, expertise and time to the Review.

THE CASE FOR CHANGE

Our terms of reference and interim report set out a number of reasons why we have carried out this Review. There is a clear case for change: the rate of detention is rising; the patient's voice is lost within processes that are out-of-date and can be uncaring; there is unacceptable overrepresentation of people from black and minority ethnic groups amongst people detained; and people with learning disabilities and or autism are at a particular disadvantage. We are also concerned that we are out-of-step with our human rights obligations.

We have taken a look at the issues that might be driving the rising rates of detention, and these are set out later in this section. We have also set out the patient experience, as we heard it from service users, which makes difficult reading for the professionals involved in this Review, but brings some of the shadows of detention into the light. We have also addressed our position on human rights.

In 2017-18:



49,551

people were detained.¹



8x

Black people were over 8x more likely to be on a Community Treatment Order.²



4x

Black people were 4x more likely to be detained² than white people.



40%

From 2005-06 to 2015-16, the reported use of the Mental Health Act to detain people in hospital increased by 40%.³



£18,315

The basic costs of detention under the Mental Health Act have been estimated to be £18,315⁴ per average 45-day admission.



Once I was detained everyone stopped listening to me.



I was treated like a criminal but I was never a danger to anyone but myself.



Access to my children was treated like a reward for 'good behaviour'.



You can get out of hospital by becoming compliant rather than disagreeing with 'those that know'.

¹ Excludes short term detention orders and Community Treatment Orders.

² NHS Digital. Mental Health Act Statistics, Annual Figures 2017-18. <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2017-18-annual-figures>.

³ CQC. Monitoring the Mental Health Act 2016-17. <https://www.cqc.org.uk/publications/major-report/monitoring-mental-health-act-report#old-reports>.

⁴ 'Services of people with mental health problems,' 'Community-based health care staff' and 'Hospital-based health care staff' - Curtis, L and Burns, A. Unit Costs of Health and Social Care 2017. Personal Social Services Research Unit, University of Kent, 2017. <http://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2017/>; NHS Benchmarking figures.

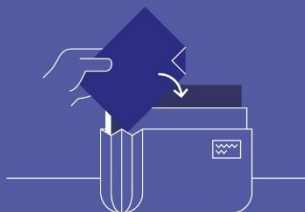
A person's journey through the Mental Health Act

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.

UNDERSTANDING RISING RATES OF DETENTION

Rates of compulsory detentions in psychiatric hospital have more than doubled since 1983, with the steepest rises in the last decade and late 1980s/early '90s. From 2005-06 to 2015-16, the reported number of uses of the Mental Health Act to detain people in hospital increased by 40%. However, emerging data from the last three years suggest that this trend may be changing²⁰. Most of the rise in England is the result of people being brought in to detention straight from the community, rather than people who started off in hospital voluntarily but were later detained against their will. There has been a steep rise in the use of the short-term detention for assessment under section 2 of the MHA (rather than the longer-term detention for treatment under section 3). But, because of deficiencies with the data, we are unable to say how far the rise in detentions reflects more people being detained; or whether we are seeing the same people being detained more often; or if the over-representation of people of ethnic minority groups is going up or down. Better routine data-recording should be a priority in this area.

The MHA Review, supported by the NIHR Mental Health Policy Research Unit, has looked at previous research, and available national and international data. The findings are outlined below, and further detail can be found in the summary paper at Annex C.

Societal factors

The number of detentions has risen more steeply than the rate of detentions. The rate of involuntary hospitalisations per 100,000 population was 51.7 in 1988/9 compared to 114.1 in 2015/16. The English population has increased by about 20% over the last 30 years. Available data suggest a rise in the numbers of people with common mental disorders but rates of psychosis has remained broadly stable²¹ over the past 25 years, and this is reflected in an increasing number of people seen by secondary mental health services²².

²⁰ Due to changes in data collection it has not been possible to consistently look at trends from 1980s to present day. The detailed assessment of rates and potential drivers focuses on the period up to 2015/16, when data collection changed from KP90. Emerging data from the NHS Benchmarking Network suggests that rates of detention may be slowing. However, as this is only available for the last three years we have not been able to conduct any meaningful scrutiny of trends and the interaction with different drivers for detention rates.

²¹ Adult Psychiatric Morbidity Survey 2014 - <https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-of-mental-health-and-wellbeing-england-2014>

²² Mental Health Bulletin 2016/17 - <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/mental-health-bulletin-2016-17-annual-report>

The impact of changes in the social and economic climate since 1983 on detention rates is unclear. Nationally, changes in levels of unemployment, income inequality, relative poverty and social fragmentation are not clearly associated with changes in detention rates, although there is a corresponding rise for some indicators of hardship (e.g. rates of benefits sanctions). There may be some specific aspects of the experience and circumstances of mental health service users that are associated with rising rates. Drug use, for example, has declined in the general population²³ but has increased among patients requiring inpatient admission in the past decade²⁴.

Legal factors

Although there has only been limited research in this area, we think that around half of patients on adult psychiatric wards may lack the mental capacity either to consent to their admissions or all or part of their treatment. One English study²⁵ found that 22% of patients on an adult psychiatric ward lacked capacity to make decisions on treatment but were not actively objecting to it. Although capacity is decision-specific, this would suggest that the same patients also lacked capacity to consent to their admissions but, again, were not objecting to it. If this pattern were to be the same for other wards across the country, there may be about 20,000 non-objecting patients who lack capacity admitted to psychiatric hospital each year.

Case law from the European Court of Human Rights (ECHR) and the UK Supreme Court now means that in most circumstances a person being admitted to a psychiatric hospital who does not have capacity to consent to their admission must be seen as being deprived of their liberty. That means that, even if they are not actively objecting, patients cannot legally be 'voluntarily' or 'informally' admitted to hospital for treatment, and they must be admitted under a formal legal framework. The Deprivation of Liberty Safeguards (DoLS) were introduced to the Mental Capacity Act (MCA) in 2009 to allow patients with impaired decision-making capacity to be deprived of their liberty under the MCA rather than the MHA in some situations, including where they were not objecting to admission or treatment for a mental disorder. However, fewer than 4,000 DoLS applications were completed for

²³ Crime Survey of England and Wales 2016/17 - <https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2016-to-2017-csew>

²⁴ Hospital Admitted Patient Care Activity 2017/18 - <https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2017-18>

²⁵ Owen et al (2008) "Mental Capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study". *BMJ* 337:a448

patients in psychiatric hospitals last year²⁶. That indicates that MHA detention could now be used for the majority of non-objecting patients who lack capacity, and this could on its own explain nearly all of the increases in detentions in the last decade. It is likely to be a major contributor to the sharp rise in detentions since 2008. This matters, because it means that the MHA is being used in situations very far from those for which formal detention had previously been envisaged, as a tool to remedy a legal problem, rather than a mechanism to address the specific needs of the individuals concerned. Further, whilst the caselaw was not designed to increase the use of coercion, but rather to recognise the width of the scope of the concept of deprivation of liberty, the fact that the MHA is routinely being used as part of the legal response means that a set of (potentially) coercive tools is now being used across a very much wider population than was previously considered to be appropriate.

Service provision

Data from NHS reference costs indicate overall inflation-adjusted NHS mental health spending per head of population has been stable over the last 15 years. However, the limited available government data suggests the number of service users in contact with secondary community mental health services has risen sharply in recent years²⁷. Available data suggest that in the last decade, the average spend per service users in contact with secondary mental health services has reduced, and there is some indication that the number of times someone has contact with their community mental health team has also reduced. There has also been a reduction in real-terms spending in adult social care – which will have impacted on Local Authority based social care MH services – which is mostly concentrated in community care²⁸. This increase in the number of people seen by mental health services and the stretch being put on their resources might mean that services have got better at identifying people who need to be detained, but worse at being able to provide interventions to prevent detention. However, as discussed in more detail in the section on Tackling Rising Rates, not much is known about the impact of changes to the delivery of mental healthcare over time, or what services or elements of care are most

²⁶ NHS Digital. Mental Capacity Act (2005) Deprivation of Liberty Safeguards, England 2017/18. Published 02 October 2018 <https://digital.nhs.uk/data-and-information/publications/statistical/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments/annual-report-2017-18-england>

²⁷ This increase in the number patients seen by mental health services is corroborated by a FOI request by Community Care magazine, which indicated there was an 18% increase in referrals to Crisis Resolution Home Treatment teams; a 19% increase in referrals to Community Mental Health Teams and a 100% increase in referrals to Psychiatric Liaison teams between 2010-2015 (McNicol 2015)

²⁸ Institute for Fiscal Studies (2018) Changes in councils' adult social care and overall service spending in England, 2009–10 to 2017–18 <https://www.ifs.org.uk/publications/13066>

likely to prevent detention²⁹. We also do not know, from empirical evidence, whether there has been a change in clinicians' perceptions of risk and attitudes to patient safety. Added to this, improved understanding of mental health conditions on the part of the police may have contributed to the rise: more patients, who might otherwise not have come to the attention of the NHS, or local authority social services departments, are now brought to hospital and places of safety by the police and subsequently detained.

We have seen a drive towards deinstitutionalisation of mental health acute care since the 1960s³⁰, mirroring the position in other countries. Inpatient bed provision has fallen substantially since the 1980s, while compulsory admissions have risen. It is unclear how far these two things are related. A study from 2011 using national data³¹, found that, rises in total number of compulsory (rather than voluntary) admissions more typically followed bed cuts than preceded them. These may be linked, e.g. because decisions to admit are delayed, until a patient is so ill they are deemed to require detention because of bed pressures. The increased proportion of detained patients on wards may also have made the environment on inpatient wards more disturbed and restrictive³², potentially making patients less willing to accept voluntary admission.

However, double-counting of detentions is also more likely to have occurred when beds are scarce and patients are moved around the system more (i.e. each time they are moved to a new hospital this is counted as a new detention, rather than a continuing one)³³. This could create a false rise in recorded detention rates. A national study did not find evidence of higher rates of detention in areas facing more bed pressures (i.e. with higher bed occupancy rates), though any relationship may have been masked because bed occupancy rates being artificially capped at 100% in official stats³⁴, and the international picture shows a clear association between higher rates of detention and having more, not fewer, psychiatric beds³⁵. In England, cuts to bed numbers happened alongside an expansion in community crisis care.

²⁹ Bone, J. McCloud, T. Scott, H. et al. (in prep) "Interventions to reduce compulsory psychiatric hospital admissions: a rapid evidence synthesis"

³⁰ : It is acknowledged that this trend is not universal and some service users (e.g. those with learning disabilities or autism) have seen an increased focus on institutionalisation, and there are also concerns around independent living support being eroded.

³¹ Keown P. Weich S, Bhui K. (2011) "Association between provision of mental illness beds and rate of involuntary admissions in the NHS in England 1988-2008: ecological study" *BMJ* 343:d3736

³² MIND (2016) "Use of physical restraint still widespread" (Web resource: published 21/09/16) <https://www.mind.org.uk/news-campaigns/news/use-of-physical-restraint-still-widespread/#.W9GOcHtKi71>

³³ This was only an issue until 2016, under the old KP90 data recording system.

³⁴ Weich et al. 2014 <https://www.ncbi.nlm.nih.gov/books/NBK26374>

³⁵ 16. Sheridan-Rains, L. Zenina, T. Casanova-Dias, M. et al. (in prep) "An international comparative study of the epidemiology and legislation of Involuntary Hospitalisation"

Data recording

Another possible reason for the rising rates of detention identified is around changes in, or quality of, data recording. As mentioned above, the double counting in numbers of detentions has inflated numbers, and this effect may have been augmented more recently because of increased numbers of transfers between hospitals. The CQC have also suggested that improvements in data reporting by service providers could have contributed to the rise in recorded detentions³⁶. A detailed analysis of local detentions data from six London boroughs conducted for the MHA Review found rising rates were much less marked than the national data suggested³⁷. However, it is unclear how much the data recording issues have led to a misleading rise in recorded detentions nationally.

Conclusions

Although there has only been limited research into the question of what is leading to rising rates of detention, that does not mean that improvements to the MHA, alongside mental health care and service provision are not part of the solution. Later in this report, we will be making recommendations across all of the issues discussed above.

SERVICE USER EXPERIENCE

Service users have been at the heart of this Review, and we want to make sure their voices are clearly heard in this report. This section pulls together some key themes from the patient experiences that have been shared with us through our service users and carers survey, individual and group submissions, focus groups, engagement events and service user and carer group. We would like to thank those who contributed to debates, shared views and opinions and often revisited difficult or traumatic periods of their lives in order to help us. We should also like to thank any who facilitated feedback or made their own contributions as relatives, carers and friends. And in particular, we would like to thank our Service User and Carer Group which has been invaluable in helping us to shape our recommendations. Patients and carers have told us it is vital that their experiences, and their knowledge of what works best for them, are recognised and acted on, by this Review.

³⁶ Care Quality Commission (2018) "Monitoring the Mental Health Act 2016/17"

³⁷ Oram, S. Colling, C. Pritchard, M. et al. (in prep) "Patterns of use of the Mental Health Act 1983, from 2007-08 to 2016-17, in two major secondary mental healthcare providers in London."

Overall, we have been disturbed and saddened by what we have heard from patients. Only 30% of respondents to our survey of service users and carers felt that they had been treated with dignity and respect, and whilst we accept that surveys like ours can sometimes have a bias towards recording experiences at the extreme ends of the positive/negative scale, this is clearly very worrying. Too many people are detained in wards that are far below the standard anyone would want for themselves or their loved ones. We are also aware that there is sometimes a disconnect between how staff perceive the care they give, and how it is experienced by patients. We agree. Too many have found that when they have previously voiced reasonable concerns or complaints, or spoken of the trauma detention and treatment has caused them, they have been ignored, or their accounts have been dismissed as being due to symptoms of disorder (an example of epistemic injustice, see box).

Epistemic injustice occurs when a person's capacity as a person with knowledge is wrongfully denied. It is a phrase that some service users feel represents elements of their experiences during the detention process. Epistemic injustice could be when a person's credibility is challenged for no good reason and their testimony is not believed. An example might be when a person's treatment preferences are dismissed because the individual's mental health diagnosis suggests that they are unable to think clearly or rationally about their options.

Some patients have reported neglect, both of physical and psychological health, and the experience of receiving impersonal care, leaving them feeling processed rather than cared for:

- Many patients report being disparaged, disbelieved or ignored and have been subject to judgemental and paternalistic behaviour from those caring for them.
- Some patients report coercive mistreatment such as the use of access to leave, or contact with families, as levers in order to achieve compliance, for example making ward leave or access to the telephone dependent on behaviour. Forced compliance can lead to institutionalisation which can delay recovery.
- Hierarchical ward structures can mirror the negative experiences patients have had with other authority figures.
- Lack of privacy is a problem - about 1000 inpatient beds are still in multiple bedded rooms. People face arbitrarily imposed restrictions such as being shut out of bedrooms during the daytime, or locked in bedrooms at night. This can increase levels of mental ill-health.

- Many find it hard to retain links to their social networks and communities whilst detained and many lose contact with family and friends, as well as losing home, employment, or access to education. This can lead to patients being much worse off than before they were detained, for example being unable to work, homeless³⁸ or worse.
- Parents and carers of children, and those with learning disabilities or autism, told us that professionals do not always take the time to understand how best to communicate with a person with a learning disability, autism or both to try and understand what is causing their distress, or have the necessary skills to do so. We also heard that their attempts to share information and to remain supportive and involved when someone is detained have led them to be ignored or excluded because they are seen as ‘too dominant’, ‘overbearing’ or ‘over-involved’.
- We have heard repeatedly of the distressing and unacceptable experiences from people from ethnic minority communities and in particular black African Caribbean men. Fear of what may happen if you are detained, how long you may be in hospital and even if you will get out are all widespread in ethnic minority communities. Addressing the issues facing this group of people is a central priority for the Review.
- Patients detained under the criminal justice system suffer from even longer delays to access the care they need.

“A new patient kept ringing the police. They told us that if she didn’t stop then they would take the phone away. It was the only way we could talk to our families.”³⁹ - Service User

“In my Trust they have adopted the tactic of explicitly framing complaint-making by patients against staff and services as an indication that the patient is a risk to others, and formally recording this ‘risk’ in the risk assessments they use to make decisions regarding leave and discharge, etc.” Service user⁴⁰

³⁸ This impact/social dislocation is amplified and worsened, when patients are placed in Out of Area Placements for longer term rehabilitation inpatient care. (The state of care in mental health services 2014-2017 - CQC 2017).

³⁹ Service User, comment submitted to the Independent Review of the Mental Health Act

⁴⁰ Service user, comment submitted to Independent Review of the Mental Health Act

Patients also reported harassment and abuse on inpatient wards, both physical and sexual. A CQC review⁴¹ reported 1,120 sexual safety reports from Apr-June 2017, of which more than a third of the incidents (457) could be categorised as sexual assault or sexual harassment of patients or staff. Data collection is inconsistent on this, and could be improved as it is for restraint. From the data that is available we know that restraint continues to be a routine occurrence on many wards, affecting disproportionately those from ethnic minority populations, women and girls. Restraint, and particularly pain-based restraint and prone restraint, can be frightening and life threatening. Not surprisingly, sexual assaults and restraint can lead to lasting trauma for those affected.

Ward physical environments have become increasingly cold and unwelcoming with an emphasis on physical safety. A few people have even told us that the way they are treated by staff, the levels of threat and violence, the physical environment and the sound levels make hospitals seem little different to prison.

We are acutely aware that this will be an uncomfortable read. It will be difficult for some of those who provide care, or those reading this report, to comprehend and accept the poor experiences that many patients suffer. But it is essential that they find the courage to acknowledge what patients are saying has been their experience rather than what their care providers believe they provide, if care and treatment are to improve. Many of the issues we cover here have been highlighted repeatedly in CQC reports and by service users and their families. Other problems have slipped below the radar, in some cases because of low expectations of what constitutes good care, and in others because of poor quality assurance of the care provided on wards. The CQC inspection criteria should also be strengthened, for example to have a greater focus on therapeutic environments and person centred care that meets the needs of people with a range of equality characteristics. Day-to-day reporting of incidents is inconsistent and numerous and complex complaints processes prevent patients and relatives from obtaining redress. Those that do complain have told us that care can be negatively affected. All of this has allowed everyone, from local ward staff to national system leaders to overlook or even normalise poor practice.

We are also aware of the huge dedication and compassion of thousands of staff across the NHS, Local Authorities and other agencies, and how services and staff suffer when they are over-stretched, feel overwhelmed and unsupported. High bed occupancy, rapid turnover of patients, higher levels of detention, regulatory pressures, and increased administrative work and inefficient processes can all reduce time spent therapeutically with

⁴¹ Sexual safety on mental health wards, CQC Sept 2018 <https://www.cqc.org.uk/publications/major-report/sexual-safety-mental-health-wards>

patients and reduce job satisfaction for staff. Lack of staff and high levels of temporary or ill-equipped staff contribute to wards with high levels of coercion and conflict⁴². Increasing vacancies (14.3% for MH nursing⁴³, 9% for consultant posts⁴⁴, 2017) and high turnover suggest the current culture and environment do not support either staff or patients and that this is becoming normalised. Improving ward culture would improve support for staff and help potential problems to be addressed before they escalate. In addition, pressures upon community NHS and social work services can lead to problems in appropriately discharging people.

Solutions to these problems must be multifaceted, addressing the needs of patients and considering how best to encourage and maintain wards that are therapeutic and respect patients' rights. The Convention on the Rights of Persons with Disabilities (CRPD)⁴⁵ requires that no decisions about disabled persons should take place without them, so those with relevant lived experience should be involved in decision making across the system, including co-design and production with patients at ward level. Patients should be treated in a way that respects them in the context of their own lives, recognises their strengths, needs, values and experiences and provides equality of outcome regardless of any disabilities or protected characteristics. It is not enough to merely ask that people detained under the Act are listened too, nor can we achieve our goals, of fair treatment for all, if detained patients continue to have so little say in their care and treatment. Many of the legal and regulatory changes recommended in this Review are essential to driving culture change, to ensuring shared decision making becomes routine practice, and that patients' own expertise is acknowledged and valued.

"...Being sectioned was one of the most traumatic experiences of my life. Sadly, as a result of being sectioned I developed PTSD as the direct result of the way I was treated..." – Service user⁴⁶

"...I did not view the act of sectioning in my case as something that should be avoided, if you are physically exceptionally unwell you are placed in

⁴² Len Bowers et al, 'Reducing Conflict and Containment Rates on Acute Psychiatric Wards: The Safewards Cluster Randomised Controlled Trial' (2015) 52(9) International Journal of Nursing Studies 1412, 1422.

⁴³ The nursing workforce Second Report of Session 2017–19

<https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/353/353.pdf>

⁴⁴ RCPsych Census 2017 https://www.rcpsych.ac.uk/pdf/RCPsych_workforce_census_report_2017.pdf

⁴⁵ The Convention on the Rights of Persons with Disabilities (CRPD) is an international legal agreement. It exists to protect and promote the human rights of disabled people. The UK signed the treaty in 2009

⁴⁶ Comment from service user, Mental Health Act survey, Centre for Mental Health

intensive care - the same arrangement applies to your mental health when in crisis...” Service user⁴⁷

STEPS TO TACKLE THE DISPROPORTIONATE NUMBER OF PEOPLE FROM ETHNIC MINORITY⁴⁸ COMMUNITIES DETAINED UNDER THE ACT

The government noted with concern the disproportionate number of people from black and minority ethnicities detained under the Mental Health Act. Whilst experiences vary across different ethnic minority groups, we were particularly concerned by the excessively poorer experiences and outcomes of individuals from black African and Caribbean communities.

We spent a significant proportion of our time throughout the Review considering specific issues concerning different ethnic minority communities, focussing on people of black African and Caribbean heritage, and worked directly with service users, carers, communities and professionals from the outset to co-produce proposals to achieve sustained and meaningful improvements. Further details can be found in 'How the Review carried out its work' and 'A qualitative exploration of perspectives on the Mental Health Act and people of African and Caribbean descent: summary' (at Annex C).

Our core recommendations can be found in 'The Experience of people from ethnic minority communities', as well as in wider sections of the report – such as 'Policing and the MHA' and 'Data'. Most are general recommendations but will have greatest impact on those of black African and Caribbean communities.

The development of the Patient and Carer Race Equality Framework (PCREF), an organisational competence framework (OCF), will improve mental health service access and outcomes in ethnic minority people. OCFs can be developed in all organisations, such as the police and local authorities, to improve outcomes in ethnic minority people with mental health problems.

In line with the OCF, our wider recommendations include:

- Ensuring the provision of culturally-appropriate advocacy services (including Independent Mental Health Advocates) for people of ethnic minority backgrounds, in

⁴⁷ Comment from service user, Mental Health Act survey, Centre for Mental Health

⁴⁸ We have chosen the term 'ethnic minority' rather than 'Black, Asian and Minority Ethnic' (BAME) simply for the purposes of accessibility and clarity. In reality, however, these terms are often used interchangeably.

doing so responding appropriately to the diverse needs of individuals from diverse communities.

- Raising the bar for individuals to be detained under the Mental Health Act, as well as any subsequent use of Community Treatment Orders.
- Providing the opportunity for people to have more of a say in the care they receive, ensuring that people from ethnic minority backgrounds are involved in the care and treatment plans developed for them and thus increasing the likelihood that they are more acceptable.
- Increasing the opportunities available to challenge decisions about the care offered and received in a more meaningful way.
- Addressing endemic structural factors through the piloting and evaluation of behavioural interventions to combat implicit bias in decision-making.
- Reducing the use of coercion and restrictive practices within inpatient settings, including in relation to religious or spiritual practices.
- Seeking greater representation of people from ethnic minority backgrounds, especially those of black African and Caribbean heritage in key health and care professions.
- Endorsing ongoing work to explore how the use of restraint by police is reduced, encouraging police services to support people experiencing mental distress or ill health as a core part of day-to-day business.
- Extending the powers of the Mental Health Units (Use of Force) Act, 'Seni's Law', to seclusion.
- Improving the quality and consistency of data and research on ethnicity and use of the Mental Health Act across public services, including criminal justice system organisations and Mental Health Tribunals.
- Giving individuals the ability to choose which individuals from their community are involved with, and receive information about, their care.

Many will be asking how these, and indeed many other recommendations from previous reports, Codes of Practice, Quality Improvement programmes and much else, will be put into practice and become the norm, not the exception. The key to our proposals to reduce disparities and discrimination is via the PCREF across health and care services. The input of regulatory organisations such as the Care Quality Commission and the Equality and Human Rights Commission is key to supporting improvement in equality of access and

outcomes across public bodies, ensuring consistent due regard to existing statutory duties such as those under the Equality Act.

We would like to thank the significant input of individuals and communities throughout the duration of the Review in developing these recommendations to address disparities across ethnic minority groups.

HOW WE ARE MEETING OUR HUMAN RIGHTS OBLIGATIONS

As we set out in the interim report, our Review seeks to achieve a greater focus on rights-based approaches. The Human Rights Act 1998 (HRA) means that our courts and public bodies (such as the NHS) are bound by the Convention rights (as set out in Schedule 1 to the Act). The European Convention on Human Rights (ECHR) is a Council of Europe Convention and the HRA is part of domestic law. These will be unaffected by whatever is the outcome of Brexit. Interpretation of the ECHR by the European Court of Human Rights has placed increasingly strict obligations on us concerning detention and treatment of people with mental health conditions. We believe the Review's recommendations meets those demands. However, we would have made the recommendations that we have, even if they were not necessary to meet those obligations.

In addition, there are other international human rights conventions signed and ratified by the United Kingdom which are not binding on public bodies in the same way as the ECHR⁴⁹, but which set out commitments that the United Kingdom has taken upon itself. In some cases, these commitments require us to do more than the obligations contained in the ECHR. Although our courts cannot enforce compliance with these conventions, they are influential in shaping how the European Court of Human Rights interprets the ECHR, and how our courts interpret our domestic laws.

Along with the UN Convention on the Rights of the Child, the most relevant of these is the UN Convention on the Rights of Persons with Disabilities (CRPD)⁵⁰. We agree with the positive vision for disabled people that is set out within the Convention. We have used the UN Human Rights Council resolution of 28 September 2017 on human rights and mental health⁵¹ to help us interpret the CRPD. This resolution sets out important steps towards a

⁴⁹ With the exception of the status that the UN Convention on the Rights of the Child has in Wales.

⁵⁰ Not all those who may at some point experience mental illness necessarily fall within the definition of a person with disability within the meaning of the Convention, but the majority of those who would be detained under the MHA 1983 or the Deprivation of Liberty Safeguards would meet the definition.

⁵¹ <http://undocs.org/A/HRC/36/L.25>

world in which all the rights of those with mental health conditions are fully respected. The steps that are required by the resolution go far beyond the remit of this Review, but our recommendations aim to get us nearer to this goal.

However, we also need to make it clear that we do not share all the goals of the Committee on the Rights of Persons with Disabilities (the Committee) which is the UN body that oversees the CRPD. We are not alone, many people, including those with experience of detention, who have themselves played an immense role in improving the respect given to the rights of those with mental health conditions share this view.⁵² Our core concern relates to what the Committee recommended in October 2017, that the United Kingdom:

“abolish all forms of substituted decision-making concerning all spheres and areas of life by reviewing and adopting new legislation in accordance with the Convention to initiate new policies in both mental capacity and mental health laws,” and “repeal legislation and practices that authorise non-consensual involuntary, compulsory treatment and detention of persons with disabilities on the basis of actual or perceived impairment.”⁵³

It is clear that this recommendation (taken together with other statements by the Committee⁵⁴) would require fundamental changes to the MHA. It would mean that it would no longer be possible to treat someone against their will, or to detain someone who is a very serious risk either to themselves or other people. The Committee’s recommendation would also mean fundamental changes to the MCA, which allows for a person to be cared for and treated in their best interests where they lack the mental capacity to make decisions for themselves.

The Committee’s interpretation of the CRPD is not shared by all UN bodies. The European Court of Human Rights does not agree that the CRPD prevents involuntary treatment and detention... Our obligations under the ECHR (as interpreted by the European Court of Human Rights, in particular when protecting the right to life of vulnerable individuals⁵⁵)

⁵² Reversing hard won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights on Persons with Disabilities. Freeman M et al. *Lancet Psychiatry* 2015; 2: 844-850

⁵³ Concluding Observations on the United Kingdom (3 October 2017, CRPD/C/GBR/CO/1), paras 31 and 35.

⁵⁴ The Committee’s 2014 “General Comment No. 1 on Article 12: Equal recognition before the law.” CRPD/C/GC/1, para 41; and 2015 “Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities.” para 13.

⁵⁵ Under Article 2 Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

could be understood as not only allowing involuntary detention and treatment, but actively requiring it. On this basis, we believe that we do not need to abolish the MHA, or the MCA, to achieve our goal of securing greater rights for patients.

We also want to make it clear that we believe that the Committee's interpretation of the CRPD goes too far. It could prevent intervention when a person is refusing help at that time but would stop them from doing something that they would never have done when well. For example, treatment for people who experience psychotic delusions that make them want to harm themselves or others. Individuals have a right to support, care, and treatment, and we believe that to withhold these on the basis of a disability would amount to a greater violation of their rights than detention and treatment under the MHA which is carefully regulated, and contains many safeguards. We are aware that many stakeholders are in favour of 'fusion' of mental health and mental capacity law so that detention is based purely on someone's ability (capacity) to make their own decisions (see the Future Direction Of Travel – Fusion Of The MHA and MCA section), but even this would not be enough to meet the requirements of the Committee⁵⁶. But, as the President of the Supreme Court, Lady Hale, has said, “[i]s it not inhumane to deny to a person the care and treatment he needs because he is unable to decide whether or not to have it?”⁵⁷

Our recommendations do not take on board all the changes proposed by the Committee, but we entirely agree that the MHA must be reformed to protect patient's rights. Throughout the body of the report we set out recommendations designed to support people to make their own decisions, to put a greater focus on their will and preferences, and to make sure that restrictive measures are the last, not the first, resort. We believe our recommendations are the sort of “*deliberate, targeted and concrete actions*” proposed by Dainius Pūras, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.⁵⁸

⁵⁶ The fact that the Committee were aware of the Northern Ireland legislation, which contains fusion, when delivering the Concluding Observations on the UK referred to above strongly suggests they do not consider fusion law meets their requirements.

⁵⁷ Lady Hale, “Is it time for yet another Mental Health Act?” Speech to the Royal College of Psychiatrists Annual Conference, Birmingham on 24 June 2018.

⁵⁸ Namely to (a) develop mainstream alternatives to coercion in policy with a view to legal reform; (b) develop a well-stocked basket of non-coercive alternatives in practice; (c) develop a road map to radically reduce coercive medical practices, with a view to their elimination, with the participation of diverse stakeholders, including rights holders; (d) establish an exchange of good practices between and within countries; (e) scale up research investment and quantitative and qualitative data collection to monitor progress towards these goals. Dainius Pūras, “Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (2017) A/HRC/35/21, para 66.

MENTAL CAPACITY AND DECISION MAKING IN THE MHA

Many of our recommendations for changes to the MHA include ideas and approaches from the MCA. This Act stands alongside, but separate to the MHA, covering a broad range of decision-making, and defining what it means to have the ability (or mental capacity) to make a decision. Some of our recommendations refer directly to a person's mental capacity to make specific decisions, for example the ability to choose their own Nominated Person, or to refuse a specific medical treatment. The concept of making a decision on behalf of someone who lacks capacity to make their own, in a way which is in their 'best interests' is central to the MCA. The 'best interests' approach requires the people taking the decision to take into consideration the person's past and present wishes and preferences; beliefs and values and to consult with family or others who are concerned with the person's welfare to establish what these may be. We want to do the same within the MHA.

Considering whether a person lacks capacity

Although, as set out above, we are proposing a much greater reliance upon decision-making capacity in different places, we understand the risks of doing this. During the Review we have heard how there is the potential for mental capacity to be misused. We have heard that clinicians can be too quick to assume that when a patient does not agree with the treatment proposed, it is because they lack capacity⁵⁹. We have also heard that some clinicians obstruct people who have capacity from accessing the services they need because they are able to ask for treatment for themselves⁶⁰. This could lead to tragic outcomes, for example at A&E following a suicide attempt, where a person could be turned away on the basis that the individual knows what they are doing, so they do not need assessment and/or treatment. We are recommending that the Code of Practice for the MHA and the Code of Practice for the MCA make clear in what circumstances professionals should consider whether or not someone has capacity to make decisions. In

⁵⁹ These clinicians are not complying with the third principle of the MCA, which says that the mere fact that a person makes an unwise decision does not mean that they lack capacity to make that decision.

⁶⁰ We also note here that the House of Lords Select Committee conducting post-legislative scrutiny of the MCA 2005 (HL Paper 139 (March 2014)) observed that "[t]he presumption of capacity, in particular, is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm. In some cases this is because professionals struggle to understand how to apply the principle in practice. In other cases, the evidence suggests the principle has been deliberately misappropriated to avoid taking responsibility for a vulnerable adult" (para 105).

particular, we believe it would be inappropriate to swiftly jump to a conclusion following a suicide attempt and assume someone has capacity to make the decision to leave the hospital when they may be in a state of considerable and apparent distress, or at the opposite extreme, muteness. We also think that both Codes should make clear who should carry out capacity assessments in these situations.

People with fluctuating conditions, such as bipolar disorder, may be aware that there are times when they are beginning to lose decision-making capacity. When this happens, it might be difficult for others to spot and by the time that it is spotted, they have already descended into a much more serious crisis. For this reason, we are recommending that service users set out in their ACDs (discussed later on in this report) examples of behaviour that may indicate they have lost capacity such as unusual spending patterns. This would provide important information for professionals when considering whether someone has decision making capacity.

A NOTE ABOUT LANGUAGE

We have used the words people/person, patient and service user interchangeably in this report. Our preference would always be for people/person, but sometimes the word patient or service user is needed to distinguish their role from that of, for example, the responsible clinician.

We have chosen the term 'ethnic minority' rather than 'Black, Asian and Minority Ethnic' (BAME) simply for the purposes of accessibility and clarity. In reality, however, these terms are often used interchangeably.

We have used the term 'disabled people' (in line with the approach of the Equality and Human Rights Commission) rather than 'persons with disabilities' to reflect the fact that people with an impairment are only disabled by barriers in the environment and society.

Where we have used the word Tribunal, we mean both the First Tier Tribunal (mental health) within Her Majesty's Courts and Tribunals Service (in England) and the Mental Health Review Tribunal for Wales.

NEW MENTAL HEALTH ACT PURPOSE AND PRINCIPLES

Any legislation that authorises the state to intervene in the private life of its citizens will always be controversial. The Mental Health Act gives the state what are amongst the most significant powers that it has; the power to take away someone's liberty without the commission of a criminal offence and the power to treat that person even in the face of their refusal. Because of that, we think that it is important that the purpose of the powers is clear, as should be the basis on which they should be used. We think that the Act should include a purpose that explains what it seeks to achieve, and why. This is in part because, it is vital that people are clear about why legislation is needed which, essentially, can remove their right to liberty. We also need to be able to judge the actions taken by professionals against that purpose.

We also think principles should be incorporated into the Mental Health Act. There are already guiding principles in the Code of Practice. However, there is limited awareness of these, and it seems very likely that they do not inform practice in the way they should. Further, we have heard from both service users and professionals that they have welcomed similar principles that are set out in the opening section of the Mental Capacity Act 2005.

How the Principles should be used

We are recommending that the new principles should become an introduction to the MHA, sitting 'on the face' of the Act (within, and at the front of, the body of the Act itself), and governing everything within it. They would provide the statutory basis for all actions taken under the Act, setting standards for services, and providing patients with clear expectations for their care and treatment. Our intention is that everyone, including patients and mental health professionals, should have easy access to these principles, and that they should be used to hold services to account and to guide organisations' approaches to a revised Act.

To reflect this, we have used the principles as the framework for this report. We want to show how our recommendations fit into the principles we want to see fulfilled.

Our Proposed Principles

We want the principles to have a significant impact on patients' experiences and the way services are provided. To do this it is important that they can be easily understood and remembered and that they reflect the concerns we have heard from service users.

We think that the principles need to provide for four things. These stand alone and are of equal importance:

First, we know how important it is to service users that their wishes and preferences are respected and we want to reflect this in the principles. We think the principle of **Choice and Autonomy** should include the need to enable and support the person to express their will and preferences, and to ensure that their will and preferences are given proper weight in decision-making. We should also require services to take steps to support professionals in respecting the patient, their dignity and their social and caring relationships.

Second, the Mental Health Act enables people to be detained and treated against their will but we want to see these powers used as little as necessary. 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. It is vital in our view that such powers can only be deployed proportionately. This includes supporting care within local areas, rather than through out of area placements, which often result in longer lengths of stay in detention⁶¹.

Third, 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 recover so that they can be discharged from the Act.

Fourth, 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 help to 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

⁶¹ CQC report and Killaspy et al, 2010. A Fair Deal for Mental Health Rehabilitation Services. The Psychiatrist, 34:265-267

aspirations and commitments in life and seek to understand their priorities, needs, abilities and limits’.

We are therefore recommending the following purpose and principles:

1. The purpose of this Act is to confer and authorise the powers (including coercive powers) necessary for the treatment of mental disorder and to safeguard the dignity and rights of those who are made subject to the exercise of such powers and for related purposes.
2. In exercising any powers under this Act, a person must have regard to the following principles –
 - a. Choice and Autonomy: all practicable steps must be taken to:
 - i. support a person subject to this Act to express their will and preferences;
 - ii. have particular regard to the person’s will and preferences, even where an intervention in the absence of consent is expressly authorised by this Act;
 - iii. promote the person’s dignity, and accord them due respect, including respecting their social and caring relationships; and
 - iv. take steps to ensure that the person understands their rights and entitlements whilst they are subject to the Act
 - b. Least Restriction: The exercise of any power under this Act shall be done in the least restrictive and least invasive manner consistent with the purpose and principles of this Act.
 - c. Therapeutic Benefit: care and treatment must be designed to meet the person’s needs in a timely manner within a supportive, healing environment with a view to ending the need to be subject to coercive powers under this Act.

- d. The person as an Individual: care and treatment must be provided and commissioned in a manner that:
 - i. respects and acknowledges the person's qualities, strengths, abilities, knowledge and past experience; and
 - ii. In particular, respects and acknowledges person's individual diversity including any protected characteristics under the Equality Act

Implementation

We believe that putting the principles into the Act itself will make them prominent. But, we think more is needed to make sure they become embedded in practice and that staff should consider the principles when taking every decision. The Code of Practice will require amendment to provide guidance on this. We also think all forms completed as part of the MHA process (including assessments for detention and reports for tribunals) should require clinicians to demonstrate how they have considered the principles. This will also enable CQC to assess the impact of the principles as part of its monitoring and regulation.

What we are recommending

- **A purpose and a set of principles should be included in the Act itself.**
- **There should be four new principles covering: choice and autonomy, least restriction, therapeutic benefit, and the person as an individual.**
- **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 should consider this as part of their monitoring and inspection role.**

PRINCIPLE 1 - CHOICE AND AUTONOMY

If there is one theme that runs through this Review, it is to ensure that the voice of the patient is heard louder and more distinctly, and that it carries more weight, than has been the case in the past. It is our intention that even when deprived of their liberty, patients will have a greater say in decisions, including decisions about how they are treated. We also want to make it harder to have those decisions overruled.

We want to do this for several reasons. First, because it is the right thing to do. Even when someone has been detained, they should still be able to have their choices, wishes and preferences respected more than they currently are. Secondly, because as we said in the interim report the greater the say a person has in as many aspects of their care and treatment as possible, the better the outcome for that person. So, our principle objective in this Review is to increase the number of ways the patient's voice is heard recorded and considered, and that patients are treated with the dignity and respect that all individuals are entitled to.

Our proposals are designed to ensure that the views, experience and expertise of patients are taken into account more fully and more seriously in their care and treatment. Our recommendations on advocacy, nominated person (NP), the use of shared decision-making to develop care plans and giving people more freedom in the ward are all aimed at empowering the patient and increasing their autonomy. We started this Review by practising what we are now preaching; by putting the voices of service users at the heart of our work. All the recommendations made, not just in this section but throughout the entire report, have either been instigated, shaped or transformed by the views of service users. We believe our recommendations benefit from this in the same way as the results of care benefits from the same principle across the rest of the NHS.

MAKING DECISIONS ABOUT CARE AND TREATMENT

We want to empower patients through greater choice and increased autonomy. Stakeholders and people with lived experience have been overwhelmingly in favour of increasing patients' rights over the treatments they receive. Not being able to make choices about your own treatment is one of the issues raised most often by people who

have been detained and many reports⁶² have shown that there is a desire for more autonomy around treatment choice. Many people want the right both to make the choice at the time and to be able to express their choices in advance so that this can be referred to when they are in crisis⁶³.

There is, however, still something of a mismatch between what people want and what actually happens. Although the current Code of Practice supports patient involvement in care planning, the CQC found evidence that although this is recorded in the majority of cases, there is still room for improvement. In 2016/17, 32% (1,034 of 3,253) of care plans reviewed showed no evidence of patient involvement⁶⁴.

The picture is equally patchy when it comes to advance decision-making. This may be because, though they are an expectation in the MCA advance decision-making currently only has a formal status under the Mental Health Act 1983 in very limited circumstances. The Code of Practice and NICE Guidelines do recommend the making of, and respect for, advance decision-making, but this does not seem to be reflected in practice⁶⁵.

The Review wants to address this imbalance by:

- Increasing patient involvement by making shared decision-making the basis, as far as possible, for care planning and treatment decisions made under the Act.
- Establishing a new basis for making treatment decisions which respects both the patient's expertise and knowledge and that of the clinician.
- Making it harder for clinicians to administer treatment which a patient has refused
- Strengthening challenges to treatment
- Providing in statute for people to express their choices in advance
- Recording patient views alongside every decision taken

⁶² For example, No Voice no Choice <https://www.rethink.org/news-views/2018/02/no-voice-no-choice>

⁶³ A survey of 932 subscribers to Bipolar UK (Hindley et al. unpublished) found that 88% wanted to be able to make decisions about treatment in advance

⁶⁴ CQC, Monitoring the Mental Health Act in 2016/17, 2018;

⁶⁵ "No Voice, No Choice", which set out the findings of research by Rethink Mental Illness also found that service felt that 'their choices were largely disregarded when detained under the Mental Health Act'

Patient Involvement and Shared Decision-Making

Our recommendations as set out below cover legislative changes that can be made to shift the balance of power towards the patient. But that alone will never be enough to achieve person-centred care – we know culture change is also needed if we are further to improve the patient experience and outcomes. Therapeutic relationships with patients and those that care for them should be based on trust and understanding.

“I felt a lot of things were done to me rather than with me” - Service user⁶⁶

It is widely accepted across health, and not just in mental health, that shared decision-making has positive benefits enabling patients to make informed choices about their care, as well as helping professionals to provide more personalised care through a better understanding of the person and their needs⁶⁷. However, what we have heard from patients, and the evidence from CQC quoted above, suggests that it is not practised routinely for those subject to the Mental Health Act. Of course, there are exceptions, but sadly the feedback we have received suggests this is far from the norm that it needs to be.

As set out above, we think that shared decision-making and collaborative care planning should be the basis, as far as practicable, for all care and treatment decisions made under the Act. This includes, most importantly, the development of the new Statutory Care and Treatment Plan which we recommend should be a requirement for detention under the Act and which is discussed in 'A Statutory Care and Treatment Plan'. We recommend that the Code of Practice be amended to reinforce the requirement that collaborative care planning focuses around the patient's individual needs, including considerations of cultural needs, and builds on their own knowledge and experience of their mental illness. The Code should also be clear that patients should in general have access to their care plans, unless there are sound reasons why not.

We also know that some service users may need assistance to express their views, wishes and preferences, and the Code should be amended so that in these cases care teams use supported decision-making to ensure that the patient's views are recorded and are considered. This could be, for instance through the use of pictures as with Books

⁶⁶ Comment from Service User/Carer, No Voice No Choice, Rethink Mental Illness report, published April 2018

⁶⁷ <https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making> and to 'your care' <https://www.nice.org.uk/about/nice-communities/public-involvement/your-care> <https://www.england.nhs.uk/personalisedcare> <https://www.england.nhs.uk/shared-decision-making/>

Beyond Words when spoken language is impaired⁶⁸. As set out below, advocates should also support patients in care planning except where the patient objects.

The Review also recommends that, to support implementation of shared and supported decision-making, CQC should continue to work with patients and service users to monitor involvement in care planning in a way which reflects what is most important to them (e.g. discharge-planning) as part of its mental health reviews.

Extract from NICE guidance on Shared Decision Making⁶⁹:

Shared decision making is when health professionals and patients work together. This puts people at the centre of decisions about their own treatment and care. During shared decision making, it's important that:

- Care or treatment options are **fully explored**, along with their risks and benefits
- **Different choices** available to the patient are discussed
- A **decision is reached together** with a health and social care professional

Benefits of shared decision making:

- Both people receiving and delivering care can **understand what's important to the other person.**
- People feel **supported and empowered** to make informed choices and reach a shared decision about care.
- Health and social care professionals can **tailor the care or treatment** to the needs of the individual.

⁶⁸ Hollins S, Carpenter B, Bradley E, Egerton J (2017). Using wordless books to support clinical consultations. The Journal of Mental Health Training Education and Practice, Emerald. DOI: <http://dx.doi.org/10.1108/jmhtep-03-2017-0022>

⁶⁹ www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making

For people receiving care:

- The care and support you receive **should take into account your needs and preferences.**
- **You have the right to be involved** in discussions, and make decisions about your treatment and care, together with your health or care professional.
- **Patient decision aids** support conversations and help patients make informed choices. We've developed several tools to support shared decision making for specific conditions.

Re-balancing treatment decisions

As well as ensuring that care and treatment decisions are developed collaboratively, we also want to provide a clear framework to support clinicians to make their treatment decisions in a way which ensures that the patient's views are respected. However, we do not expect clinicians to make treatment decisions which have no clinical benefit. Clinicians should make treatment decisions in light of the evidence base (which may be found for instance in NICE guidelines). However, they should also take into account the experiences and knowledge of the patient. We accept that many do this automatically, but others do not.

"My care team just didn't listen when I told them that I didn't want to take that medication – I'd had it before and it just didn't work. And the side effects were horrendous. I know myself best and I should be listened to more." Service user⁷⁰

Evidence may suggest that a particular drug is the best choice in a given situation but if, for example, the side effects of the drug are unacceptable to a patient then it may not be the best choice for the individual patient. Clinicians must accept that just as medications have untoward side effects, there are also untoward side effects from imposing decisions about treatment against a person's preferences, particularly when this is done without being required to explain why. We believe that the following approach should be adopted as a matter of course so that it reflects the approach taken more broadly in healthcare: It should apply to all treatment decisions including medication and psychological therapies:

⁷⁰ Comment from Service User, submission to Independent Review of the Mental Health Act

- The clinician discusses treatment with the patient, taking into account patient preferences, using best interests criteria as set out in the MCA where the patient lacks capacity.
- The clinician considers what treatment is clinically appropriate, taking into account the evidence base (e.g. though NICE guidelines).
- If the patient indicates a preference for a treatment that may not be the best evidenced but is still clinically appropriate, the clinician should adhere to the patient's preference where possible.
- But no clinician can be expected to provide a treatment which is not clinically appropriate, even if requested by the patient.

As we set out further below under 'Criteria for Detention', we are not recommending changing the definition of medical treatment for mental disorder, which can include treatment not just for the disorder, but also one or more of its symptoms. This can include, for example, feeding someone who has an eating disorder.

Circumstances in which Treatment Decisions can be overruled.

The paragraphs above set out our preferred approach to making treatment decisions based on shared and supported decision-making and respect for the patients' experience and expertise and knowledge. We want to give this framework power by making it more difficult for patients to be given treatments which they have refused. As already discussed, there will be circumstances in which it will still be necessary to give such treatments, but these should be exceptional, as opposed to routine, properly justified and subject to the possibility of being challenged.

We have developed an approach outlined in the Annex on Treatment Choices which sets out how this could work for drugs and invasive treatments. When a patient's choice is overruled, the treatment should only be administered in the lowest possible dose to achieve its purpose (as should always be the case whether or not the treatment has been refused), and the clinician should be required to record why they have done this, as well as be prepared in some circumstances to defend the decision. In cases where the patient is treated against their will despite having capacity, the records would need to be lodged with the provider's lead on MHA administration and be subject to scrutiny by the CQC. Requiring clinicians to give reasons why they are not following a patient's choice is not just required to comply with our human rights obligations. It is also linked to a substantial body of research in the field of procedural justice, which shows that people value fair decision-

making more than the outcome of decisions, and, in particular, that they want an explanation of rules and decisions, as well as a voice in the process.⁷¹

Challenging a treatment decision

At the moment, a patient has only very limited ability to question the treatment they are receiving in the first three months of their detention, and most decisions are taken on the basis of the opinion of the patient's Responsible Clinician alone. After three months a second opinion from a SOAD is required if the patient lacks capacity or has capacity and has not consented. Until that point, most treatments can be administered despite a patient's refusal, without any statutory requirement to explain or justify that decision. Criticism of this situation was raised as an issue by service users. Service users' unhappiness with the way they were treated, more even than the detention itself, persisted long after the period of detention or treatment was over. We are clear that the current approach does not go far enough to meet either the ECHR⁷² or the CRPD but we would have made the recommendations set out below in any event.

Our other recommendations in this chapter and the Treatment Choices Annex give patients a greater say in the treatment decisions that are made about them, making it harder to override their treatment decisions. We hope this means that patients will be happier with the treatments they receive, but if they are not, there need to be ways to challenge decisions made about them. We propose to address this in two ways; first by enabling earlier access to a SOAD, and second by giving the patient a right to challenge a treatment decision in court.

We think that it is necessary that patients (or a NP or Independent Mental Health Advocate (IMHA) on their behalf) should be able to request a SOAD from the point at which the care and treatment plan is finalised (or 14 days after admission, whichever is the earlier). We also think that there should be provision for automatic SOAD referrals in specific circumstances (set out in the Annex on Treatment Choices). This would not be an unlimited right to access a SOAD. Repeated access to the SOAD should not be permitted within a specified period of time, or without a material change in circumstances.

⁷¹ See, for instance, Blader, S. L., & Tyler, T. R. (2003). A Four-Component Model of Procedural Justice: Defining the Meaning of a "Fair" Process. *Personality and Social Psychology Bulletin*, 29(6), 747–758.

⁷² Following, in particular, the decisions of the European Court of Human Rights in *X v Finland* and *LM v Slovenia*, and the report of the Council of Europe's Committee for the Prevention on Torture on its 2016 visit to the United Kingdom.

We understand that our recommendations for SOADs contained here and in the Treatment Choices Annex represent a significant increase in their use which will in turn impact on resources. The Government and the CQC need to work together to resolve this. We think this should include consideration of SOAD fees, inclusion of SOAD work as part of the supporting professional activities (SPA) included in consultant's contracts, and/or establishing an expectation that all consultants should at some point undertake SOAD reviews. We also think that they should look at how the SOAD model can evolve, building on the range of reviews already undertaken by SOADs, and looking creatively at how technology can assist, for example thought much greater use of remote access. We do not think a substantial shift is needed from the frontline clinical workforce to the SOAD workforce to support our recommendations.

At the moment the only way for a patient to challenge the decision of the RC and SOAD is a right to appeal treatment by way of Judicial Review, but we have reached a firm conclusion that it is simply inaccessible. It is both too difficult and too expensive. We believe there should be a route of challenge to a single judge of the Tribunal, supported by non-means tested legal aid. That judge would have the power either to require the Responsible Clinician to reconsider their treatment decision or to order that a specific treatment is not given where they find that it is a disproportionate interference with the patient's rights. The judge would not have the power to order that a specific treatment is provided, but only to prevent treatment (as set out above). We do not think that the judge would, in most cases, need to obtain further clinical evidence, but we think they should have the power to request evidence (for example a medical report⁷³) if necessary. Where the patient themselves does not have capacity to bring the application, we think that either their NP or their IMHA should have the power to do so on their behalf, where the patient is unable to do this themselves, and the NP or IMHA believe that the patient would not agree to that treatment (or the NP or IMHA themselves has reason to believe the decision is not in the patient's best interests).

We recommend that a judge would have to give permission before an application is heard. This would make sure that, where possible, disputes are resolved at the hospital level, and would balance the right of patients against unmanageable resource implications (for both the Tribunal and for treating clinicians). We consider that pre-conditions for permission are that:

⁷³ e.g. similar to those available to the Court of Protection under S49 MCA

- A SOAD has confirmed that that the treatment should be given
- The patient (or their the NP or IMHA) has set out reasons for a full hearing;
- The application applies to a specific disagreement about an individual treatment decision rather than a general desire not to be detained; and this should be dealt with separately within an application for discharge); and
- Any repeat application shows a material change in circumstances.

As with any decision of the Tribunal, the provider could appeal a decision of the Tribunal in relation to treatment to the Upper Tribunal, and we would expect that it would do so on behalf of a Responsible Clinician where appropriate. Although an order made by the Tribunal judge that the Responsible Clinician cannot provide a specific treatment would normally prevent that treatment being given, we accept that the Responsible Clinician should be able to administer the medication if required when responding to unforeseen circumstances that arose after the court's decision was made.⁷⁴ Should the treatment then be continued, the patient could make another appeal to the court on the basis of a change in circumstances.

Advance Choices⁷⁵

We want patients to be able to set out, in advance, choices relating to their care and treatment when they are detained which can be used to identify their wishes and preferences when they lose capacity. This will secure the right to respect for their will and preference central to our first principle, and to the CRPD. At present, although some patients have set out their advance choices, these have no statutory footing under the MHA, except in very limited circumstances. Clinicians are unlikely to ask for or look for them and if they do, they may not be easy to find. There is no requirement for clinicians to adhere to any aspect of an advance choice or to explain why they are not following it.

⁷⁴ In other words we think that the same principle should apply as applies where a patient has been discharged from the MHA by the tribunal, following the decision of the House of Lords in *R (von Brandenburg) v East London and the City Mental Health NHS Trust & Anor* [2003] UKHL 58.

⁷⁵ Our consideration of this issue was informed by the report by KCL Report for the Independent Review of the Mental Health Act: Advance Decision-Making in Mental Health' Owen, G.S. et al. (publication forthcoming), which was commissioned for this report

“...I think certainly when a person recovers from a mental illness there is absolutely no question that they would then have the capacity to then make decisions in advance on how they would actually wish to be treated...” - Service user⁷⁶

We are recommending the introduction of statutory Advance Choice Documents (ACDs) that enable adults (see Treatment Choices Annex) to make a range of choices and statements about their care and treatment. If these are made by a person with capacity they can be authenticated by a health professional and, should be treated, in most cases, in the same way as treatment choices made at the time⁷⁷. We think that Government should consider piloting these to identify what is needed for their successful implementation.

Our view is that there should be a requirement for ACDs to be offered to everyone who has previously been detained. We also think that there is a good argument for a requirement for ACDs to be offered to those considered at heightened risk of detention. This may be a matter on which the Government will wish to consult. This limits who is offered an ACD, but anyone should be able to make one.

ACDs should have a standard format. They should enable people to make a range of choices and statements, including:

- Treatment preferences (including non-medical therapeutic approaches)
- Treatment they do not want(refusals)
- Preferences/refusals on how treatments are administered (e.g. refusal of suppositories)
- NP (see below)
- Who should be informed of their detention, care and treatment (with the potential to tailor for specific individuals)
- Communication preferences

⁷⁶ Comment from Service User/Carer, No Voice No Choice, Rethink Mental Illness report, published April 2018

⁷⁷ The exception to this is treatments in category 3 where we will allow treatment in an emergency to alleviate suffering where the person lacks capacity which would not be allowed where the person has capacity (see Treatment Choices Annex)

- Behaviour and behaviour triggers and early signs of relapse
- Circumstances which may indicate that they have lost capacity to make relevant decisions⁷⁸
- Religious or cultural requirements
- Other health needs and/or reasonable adjustments required for disability
- Crisis planning, including information about care of children/other dependents, pets, employment, housing etc

No ACD can be made that would contradict the wishes of Parliament as expressed around assisted dying unless Parliament should change the law.

Ideally, ACDs would be created collaboratively (i.e. using shared and, where appropriate, supported decision-making) between clinicians and the patient as part of the care planning process (for instance as part of care planning after discharge) and patients should be able to invite an IMHA to be part of the discussion. But, if the patient does not want their treating clinicians, and an IMHA, or anyone else to be involved in the creation of an ACD, this must be respected.

We would also expect that ACDs would be regularly reviewed and updated. This should be done as part of care-planning and following any period of detention. They must also be able to be rescinded at any point by the patient while they have capacity.

Where a patient has capacity for advance decisions, ACDs should be authenticated where possible by a health professional, unless the patient objects to this. In other words, we think that a health professional should confirm that the patient has capacity to make the choices contained in the document. We make this recommendation to remove the potential for doubt later as to whether the person had capacity to make the choices contained in the documents⁷⁹. As part of assessing capacity health professionals must give the patient information on any foreseeable consequences of an ACD, including the potential risks of refusing treatment; the fact that in certain circumstances their treatment refusals can be overridden; and that, where their treatment choices are not clinically

⁷⁸ this would not bind the professional charged with assessing their capacity at the relevant time, but would be very relevant information for them

⁷⁹ Ordinary decisions to refuse medical treatment made under the MCA do not have to be 'authenticated' in this way, but we think that it is sensible to include this requirement here because of the fluctuating nature of many mental health conditions.

appropriate, they are not going to receive them (e.g. insisting on use of any medicines which have no clinical efficacy in the particular circumstances).

Where people at risk of detention do not have capacity, they should still be encouraged, through supported decision-making, to express their wishes in advance of a potential crisis. This could use the same form as an ACD but would not be authenticated so would not hold the additional weight we are recommending for authenticated ACDs. However, the expectation would be that they would be considered by clinicians making treatment decisions as part of the best interests assessment we are recommending for those without capacity (see Treatment Choices Annex).

As set out above, and in the Treatment Choices Annex, decisions taken in advance via an ACD should be treated in the same way as decisions made with capacity at the time and where ACDs are not authenticated they should still be considered by clinicians as an expression of a patient's past wishes and preferences.

ACDs should (with the patient's consent) be part of a person's medical records, should be flagged to clinicians on electronic records, and a copy should be given to the patient. We think there is a good argument for storing ACDs on a national database, in line with data security and information governance law and good practice, so that they are easily accessible once a patient is detained, and which will allow effective monitoring and data collection. However, we know this needs further consideration and in the meantime, we recommend that ACDs should be stored on the Provider's database, flagged on the patients' Personal Health Record, and recorded in the statutory care plan (see Care Planning chapter).

Clinicians should record that they have taken reasonable steps to locate an ACD, and indicate that they intend to take account of its contents. If they do not intend to do that, then their reasons for so doing must be recorded at the time. Transition to a digital MHA will make this far easier (see Digital Enablers chapter).

With the patient's consent, elements of the ACD, in particular crisis preferences, may be made available to other groups, such as local crisis services and the police, via health staff working in liaison roles.

An advance decision to refuse treatment that complies with the requirements of the MCA will always be taken into account as an expression of the person's past wishes and preferences in respect of the medical treatment for mental disorder that is being considered. However, only an 'authenticated' ACD will carry with it the higher status that we have set out. This is because, as we explain above, 'authentication' constitutes confirmation that the person had capacity to make the advance decision, which we consider to be particularly important in the mental health context. Where the treatment is

not for mental disorder, an advance decision to refuse treatment complying with the requirements of the MCA will be binding in the same way it would be in any other context.

ACDs and Tribunals

As the Care and Treatment Plan would include reference to the ACD, the Tribunal would have it before them at each hearing considering discharge. It would therefore be able to consider the extent to which the overall care and treatment plan complied with the patient's wishes and preferences as stated in advance. This would be particularly important in any application brought on behalf of a patient where they did not have capacity to do so, and might well also lack capacity to make decisions as to treatment

Patients without capacity to make treatment decisions

Where patients do not have capacity to make specific treatment decisions at the time, we want to ensure that their past wishes and preferences are considered by clinicians when making treatment decisions. We are therefore proposing that clinicians are required to use the 'best interest' criteria at section 4 of the Mental Capacity Act as a framework for ensuring they consider patients views where patients do not have capacity to make treatment decisions or an authenticated ACD. Further information on this can be found in the Treatment Choices Annex.

Consenting to admission in advance

Linked to the question of what choices people can make in advance about their treatment, we have heard from some service users that they want to be able to consent, in advance at a time when they are well to being admitted, if they are unwell and lack capacity in the future. The effect of the Cheshire West decision⁸⁰ means that, if they lack capacity, including as a result of a decline in their mental health, a hospital cannot lawfully admit them except as a detained patient under the MHA or under the MCA following an authorisation under the Deprivation of Liberty Safeguards (in future the Liberty Protection Safeguards). That means they cannot be a voluntary, or 'informal' patient who is not 'detained' by the state.

⁸⁰ Cheshire West sets out the criteria for what amounts to a deprivation of liberty, and this includes any admission for assessment or treatment for mental disorder when the person cannot (at that point) consent to that admission, because they lack capacity

In line with our principles, the MCA and with Article 12 of the CRPD, we think that people should be supported to make decisions that have effect, even when they lack mental capacity. We have therefore considered whether someone should be able to give informed consent in advance to their admission, thus making them a voluntary patient even if they are not consenting at the time. We think this could be done based on the model proposed by the Law Commission in its Mental Capacity and Deprivation of Liberty report⁸¹. This model provided a ‘get out’ clause to ensure that a person should not be held to their earlier advance consent where it is unreasonable to do so, which was endorsed by the Joint Committee on Human Rights thus making them a voluntary patient even if they are not consenting at the time.⁸²

Whilst not included in the Law Commission’s recommendations, this model could also be extended to allow a person to appoint an attorney to consent to their admission on their behalf.

However, we recognise that there are strong arguments against the Law Commission’s proposal, and the Government did not include it in the Mental Capacity (Amendment) Bill.⁸³ Our chief concern is that, under these circumstances, informal patients do not have access to the safeguards that someone detained under the MHA has (for example, the powers of a NP, or the right to appeal to a Tribunal), or those provided by the DoLS/LPS. Another problem is that it may not be possible to tell whether the exact conditions they are being admitted to are the same as the ones they imagined when consenting in advance. Not all wards provide the same levels of care and a person might end up confined in a setting which, if they were able to, they would not have agreed to. Also, we are worried that patients could be coerced, after they have been admitted, into not demonstrating an objection to being there, meaning they would remain informal when they should have transferred to a formal detention under the MHA. Or they may be so unwell or medicated that they are not able to express an objection.

⁸¹ Law Com No 327, March 2017, paragraphs 15.2-15.24.

⁸² Most recently in its legislative scrutiny report on the Mental Capacity (Amendment) Bill: <https://www.parliament.uk/business/committees/committees-a-z/joint-select/human-rights-committee/news-parliament-2017/mental-capacity-bill-report-published-17-19/>.

⁸³ The government did, though, accept that advance consent was, in principle, legally valid as a concept Lord O’Shaughnessy pointing at Committee Stage in the House of Lords to guidance already issued by the Government to the effect that consent given to palliative care could include consent to what would otherwise be a deprivation of liberty at the point that the person lost capacity to agree to be in the hospital or hospice (Hansard, HL Deb 22 October 2018, col 736).

Some of these risks could be mitigated by – for instance – time-limiting the period for which any advance consent was valid (for example to two weeks). Further, if, as we are recommending above, advocates are available for patients making ACDs, as well as for all in-patients (including those who are informal), IMHAs could assist in drawing up a consent, and they could be required to consider whether there is any reason that the consent would no longer be valid. But the complexity of the issues and the nature of the rights at stake meant that few issues caused as much discussion during the course of the Review as this one. Perhaps not surprisingly opinions were split and remained split at the end. Whilst the Chair and Vice Chairs were broadly in favour, many others were not. The differences did not represent any particular professional perspective, and service users were as divided as the professionals. Because the Review has strived very hard for consensus, that meant we agreed not to make a firm recommendation. But we do think that the Government should consult further on this.

We do however want to say that if advance consent to confinement were ever introduced we do not think it should include advance consent to any specific type of treatment. It could give valuable information about the person's wishes and preferences concerning treatment, but should not do more than that. We also think that advance consent should not mean there is a change to the level of detention criteria for that person, or that they could be admitted earlier under section, before they have reached the criteria for detention. We know that some service users, particularly those with a diagnosis of bipolar disorder, would want this to be possible. We are not recommending this, but we do think that people could, through their ACD, make clear what a 'real likelihood of significant harm' looks like for them as an individual and also what behavioural indicators are likely to mean that they have lost capacity to make decisions about their care and treatment (see above). This should help professionals to make more accurate individual decisions about whether the person should be detained.

Co-production

Looking beyond an individual's treatment, the NHS Five Year Forward View for Mental Health recommended 'co-production with experts-by-experience should also be a standard approach to commissioning and service design' across the mental health sector but this is not yet happening everywhere. We think it is vital that such approaches are mainstreamed across mental health services.

What we are recommending

- **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**
- **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).**
- **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**
- **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**
- **Patients should be able to request a 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.**
- **Patients should be able to appeal treatment decisions at the Mental Health Tribunal following a SOAD review.**
- **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.**
- **The Government should consult upon:**
 - **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**
 - **what safeguards would be required.**
- **Mental healthcare providers should be required to demonstrate that they are co-producing mental health services, including those used by patients under the Mental Health Act**

FAMILY AND CARER INVOLVEMENT

Service users and stakeholders consistently told the Review that the current model of family and carer involvement is outdated, variable, and insufficient. This is particularly true for the role of the Nearest Relative (NR). The patient's NR has certain powers to protect the rights of the patient, but the patient currently has no say over who fulfils this role. The NR is automatically appointed through an outdated list that places 'conventional' relatives within an inflexible hierarchical structure. This reflects neither the makeup of modern families and their diverse cultures, nor the wishes of the patient themselves.

People with experience of detention, their family members, and mental health professionals gave a wide range of examples of inappropriate people serving as a patient's NR, or instances where patients who had no NR because the default person was unsuitable. However, it was also clear that where the NR role is held by the right person, as is often the case, it has real and substantial value for both patients and carers. The fact that the role and powers are set in statute means that professionals are bound to give the views of the NR more weight. We want to make sure that in future, as far as possible, people should be able to make their own choices about who should fulfil this role for them.

A new Nominated Person to replace the Nearest Relative

Our recommendations will allow the patient to choose their own Nominated Person (NP) either prior to detention, at the point of assessment for detention or whilst detained through a new nomination process. We understand that some individuals will be detained at a point when they do not have capacity to make decisions. We recognise that the level of someone's 'capacity' to make a decision is different depending on the type, and complexity, of the decision they are making. A patient may have capacity to make one decision (for example, about their own treatment) but not another (for example, who should be their NP). Care needs to be taken to assess capacity specifically in relation to the NP nomination, so that, wherever possible, patients are supported to choose their own NP.

"...my mother used to perform this role but she now has Alzheimer's and she lacks capacity. Under the current system I cannot specify who I wish to serve as my nearest relative. The responsibility would automatically go to my oldest sister - a sister I do not get on with..."⁸⁴ – Service User

⁸⁴ Service user, comment in Mental Health Act survey

Some people may not have capacity to make a nomination themselves and will not have previously nominated anyone. Under the revised Scottish system, there is no default Named Person (their NP equivalent) if the patient has not nominated anyone, but there are alternative mechanisms in place to represent the patient. The Review feels that the people who most need the support of an NP will be left vulnerable if there is no ‘fall back’ mechanism for nominating a person in these circumstances. This may include people who have never been detained before, and individuals and communities with limited trust in, or minimal engagement with, mental health services.

For this reason, we are proposing a fall back Interim Nominated Person (INP) mechanism. An Approved Mental Health Professional (AMHP), when making an application for detention under the MHA, would appoint the INP, working to guidance to identify the friend or relative most suitable to fulfil the role. This guidance would suggest which individuals an AMHP should first approach (for example, those identified as next of kin⁸⁵, or those at the top of the current revised NR list) as well as setting out what they should look for in an appropriate INP. As soon as the patient regains capacity they would be able to choose their own NP. If a family member disputes the selection of the INP, they could go to court to have this changed (see 'Displacing the Nominated Person' below).

We also understand that some service users do not want anyone involved, and, if they have capacity to do so, they would be able to use the nomination process to ‘opt out’ from having either a NP or an INP. Additionally, section 116 of the MHA allows the court to appoint a local authority to have the powers of the NR, particularly in cases of long term detention in which patients have no NR. Whilst this provision should continue, there is significant scope for improved practice and stronger guidance in this area to make sure that this safeguard is used more effectively for everyone that might benefit from it.

The Powers of the Nominated Person

The powers of the NP and INP would largely be based on those currently exercised by NRs. This includes, as now, the ability to block detention (for treatment but not for assessment), to discharge a patient and to appeal to the Tribunal where their discharge of a patient has been barred by the Responsible Clinician. We also recommend upgrading the current right to be notified about a renewal of a patient’s detention, extension of a CTO, and transfer from one hospital to another, to be a right for the NP to be consulted.

⁸⁵ A term which we recognise has no formal legal status, but is one that is commonly understood.

Additionally, where a patient has given consent, NPs should have the right to be consulted on care plans⁸⁶. We know that the closest family and friends will often be an invaluable source of information about the patient's wishes and preferences, as well as what treatment does and does not work best for them. Where a patient lacks capacity, the 'Best Interests' approach to treatment decisions that we outlined in 'Making decisions about care and treatment' would also mean that family should be consulted (where practical and appropriate), and the MHA Code of Practice should spell out how this could work. The right to be consulted on care plans will allow the NP to engage directly and meaningfully with how their loved one is being treated.

We heard that, in order to prompt a meaningful discussion on care planning, some have had to threaten to use their discharge power, even though this was not their primary intention – clearly not the best outcome for anyone. Involvement in care planning is equally applicable to all individuals detained under the MHA, and we therefore believe that a 'limited' NP provision (without the right to discharge) should be rolled out to Part III patients, where they do not currently have a right to an NR.

Further, and as discussed in 'Making decisions about care and treatment', we think that the NP should be able to appeal clinical treatment decisions. This should be an option only where the patient is unable to do this themselves, and the NP believes that the patient would not agree to that treatment or the NP themselves has reason to believe the decision is not in the patient's best interests.

Displacing the Nominated Person

While our recommendations will reduce the chances that an inappropriate person will be selected as NP or INP, there is still a risk this will happen. Currently an AMHP can choose not to contact an inappropriate NR where doing so would infringe the patient's rights under Article 8 of the ECHR⁸⁷, but must apply to the county court to appoint an alternative NR. The delay and complexity of doing so means that patients are often left without an NR. We recommend instead that the AMHP should be able to select a more appropriate INP, and that the court would become involved only when this selection overrides a patient's nomination or is contested by a friend or relative who believes that they would be a more appropriate INP. Applications to the court should be permitted by the AMHP when

⁸⁶ Including the statutory care plan we are also recommending in 'Care planning and aftercare'

⁸⁷ See *TW v Enfield Borough Council* [2014] EWCA Civ 362

intending to overrule an existing nomination, or directly by a friend or relative who considers themselves better placed to take on the INP role.

Currently if the NR inappropriately exercises their power to block admission, the only way to admit the patient is to remove ('displace') the NR. The AMHP currently applies to the County Court to do this, and once the court has removed the NR, they can play no further statutory role in supporting the patient during their detention. This is harmful where the NR, despite blocking admission to hospital, would in all other respects be the best person to look after the patient's interests. Our recommendation is to give the court the power to temporarily overrule the NP whilst allowing them to stay in place as NP. We also think that applications concerning NPs should be dealt with by the Mental Health Tribunal rather than the county court, since they have greater expertise and experience in this kind of decision making.

Improved involvement of loved ones and friends

We are aware that placing all of these responsibilities on the NP alone, even when they have been nominated by the patient, carries certain risks to the wellbeing of the patient and their wider relationships. We heard from many loved ones and carers that they have been excluded from all involvement, including the most basic information, and there is a danger this could continue to happen if they are not the NP. We also heard that many service users want to be able to access the wider support of their family and loved ones, in addition to the role of the NP.

We therefore recommend that, in addition to the NP, who may or may not be a family member, patients should be given the opportunity to record who else they would like to receive information about their care. They should be able to request this at any time, but most particularly at the time of making an NP nomination or an ACD. This should ensure more meaningful involvement and should also help staff to share information without worrying about potential breaches to patient confidentiality, especially where the person lacks capacity to make relevant decisions when they are in hospital.

Many NRs feel that they have inadequate information and support to be effective in their role. NPs should be given improved support, which could include courses provided by recovery colleges, support lines or online materials. These should be designed to be accessible to all those who need it. We think that the government should consult on how this should be made available.

Children and young people

In line with our wider recommendations, young people aged 16 and over should also have a right to choose a NP. The position for children under 16 is particularly complicated and we think it should be considered as part of the consultation we are recommending in 'Children and Young People'.

There needs to be careful consideration of how the powers and rights of the NP will interact with other areas of the system, including care orders, guardianship and child arrangement orders, where the overlap with parental responsibility is particularly important. As a minimum, parents of children and young people who are detained under the Act should have access to appropriate information, whether or not they have been selected to act as the NP (or INP). Where someone aged 16 or 17 does not nominate anyone, the default INP should be the parent.

Conclusions

Appointing the right individual as NP will mean fewer cases of unsuitable people being automatically selected or patients being left without anyone appointed to the role. In turn, this should mean fewer legal challenges in relation to the appointment of NPs, and will bring us closer to the supported decision-making model of the UNCRPD.

What we are recommending

- **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.**
- **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.**
- **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.**
- **NPs should have the right to be consulted on care plans.**
- **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.**
- **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.**

- **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.**
- **NPs should have a power to challenge treatment before the Mental Health Tribunal where the patient does not have capacity to do it themselves.**
- **NPs should be given improved support, which could include courses provided by recovery colleges, support lines or online materials.**

ADVOCACY

Patients detained under most sections of the MHA (as well as those under guardianship or on a CTO) have a right to an Independent Mental Health Act Advocate (IMHA). The Review received strong evidence that advocacy enables patients to understand and exercise their rights, and gives them support to make shared decisions. Advocacy is also welcomed by clinicians for the same reasons. Despite this there remain concerns around access, eligibility, and the quality and commissioning of advocacy services by local authorities.

Eligibility

We want to enhance and extend advocacy provision. There is widespread support among organisations representing patients and professionals and from individuals with experience of admission in hospital, that voluntary (informal) inpatients, as well as those detained against their will, should be entitled to an IMHA. This already happens in Wales, but not in England. Successive CQC reports⁸⁸ and research evidence⁸⁹ have found that patients who are in hospital voluntarily can be inadequately informed about their rights and status and subject to coercion to comply (with things like a ban on leaving hospital grounds, or taking medication) because of the threat of compulsory detention. Extending IMHA eligibility to these inpatients will make sure that informal admission is truly voluntary and that these patients are involved when clinicians consider making the admission compulsory.

⁸⁸ CQC Monitoring the Mental Health Act: 2011-12; 2012-13; 2013-14; 2014-15

⁸⁹ Szmukler G. 2018; Bindman J, et al. 2005; Burns T, et al. 2016; Perry B, et al. 2016

“At my last hospital I had a fantastic advocate who really helped me when I wasn’t feeling well enough to speak up for myself. This time there was nobody. Everyone should have an advocate to help them when they need it most.” Service User⁹⁰

We also think service users in the community, who are at risk of detention or who have previously been detained under the MHA, should have the right to support from an IMHA when drafting ACDs, as set out earlier in this report. This is in addition to any existing form of advocacy (such as Care Act advocates). This will help to make sure the patient’s choices are better informed and can be clearly recorded in a way which may prevent confusion or dispute later on. Although advocates frequently support patients to make their wishes and preferences known, making this a statutory role will prevent it being seen as an optional extra by commissioners.

Whilst in principle advocacy should be available at all stages of the process, we are aware that there will be times when this may be impracticable, or where finding an advocate may introduce unnecessary delay which is not in the best interest of the patient – the most obvious example being at the point of assessment for a possible detention. For this reason, there is no statutory right to advocacy at assessment. We think further research and piloting should be undertaken to identify what value advocacy might have during the assessment process, especially for ethnic minority groups, and how best this might be achieved – for example, at centralised health-based places of safety such as the Healthy London Partnership⁹¹.

Access

Despite a right to an advocate for those subject to the MHA, we heard evidence that in some areas IMHA services are insufficiently promoted and difficult for patients to access. We want the right to an advocate to be consistently promoted and delivered across Trusts and services so that all those who would benefit from advocacy receive it. This would be supported by training for Trusts’ clinical staff on the role and benefits of advocacy. ‘Opt out’ service models have been successful where they have been developed and delivered, such as those provided by Advocacy Focus and seAp (Plymouth and Cornwall), but the use of this model is patchy. Under the opt out model, patients are automatically referred and advocates regularly visit wards to speak to patients. Opt out models should also be

⁹⁰ Comment from Service User, submission to Independent Review of the Mental Health Act

⁹¹ <https://www.healthylondon.org/resource/slams-centralised-health-based-place-of-safety-evaluation-2018/>

developed to ensure that those in the community with a right to an IMHA (such as those on CTOs) are proactively approached.

Role

Although some aspects of the IMHA role are set out in statute, they are not meant to be exhaustive. However, anecdotal evidence suggests that in some cases the limited resources mean that only the aspects set out in the Act are being delivered. While advocates will often provide broader support, we believe there is a reasonable case to amend the MHA to give advocates a formal role in supporting patients to take part in their care planning, in line with our wider recommendations for a statutory care and treatment plan and improved discharge and after-care planning. IMHAs should also advise voluntary inpatients on the comparative rights/safeguards for voluntary patients compared to detained patients.

We think that IMHAs should be able to challenge treatment decisions, and make applications for discharge, on behalf of the patient where the patient lacks capacity to do so (see 'Making decisions about care and treatment'). We also think that IMHAs should have the power to challenge treatment where they have reason to believe the decision is not in the patient's best interests; this power is similar to the duty that Care Act advocates have.⁹²

Quality

We are also proposing that local authority commissioners consistently gather greater feedback from clinical staff on the performance of advocates, alongside feedback from advocacy clients. Providers should also be required to provide quarterly reports to their commissioners about issues and trends, incorporating input from trust staff, families and carers, and clients. We know that advocacy organisations themselves have valuable information about other services for which they have no outlet. We believe these insights should be shared with the CQC.

⁹² See Regulation 5(8) of The Care and Support (Independent Advocacy Support) Regulations 2014, which provides that, “[w]here the individual does not have capacity, or is not competent, to challenge a decision made in the exercise of the assessment or planning function, the independent advocate must challenge the decision if the independent advocate considers the decision to be inconsistent with the authority’s general duty under section 1 of the Act (duty to promote the individual’s wellbeing).”

Better training for advocates is also required, but there needs to be a balance between ensuring advocates have adequate training whilst encouraging smaller providers of advocacy services for those from excluded communities. Consultation is needed on the shape of future advocacy services, weighing up the normal route to professionalism (including standards, accreditation, inspection and registration) against both the inevitable loss of informality that would result and the potential to exclude bespoke services which cater for people identifying with specific protected characteristics.

When delivered well, advocacy can be particularly valuable to ethnic minority communities, but this is where the biggest gaps exist. It is therefore vital to develop advocates' cultural competence, for example through the use of placements to allow advocates to understand the needs of different communities. The Code of Practice, existing regulations and the Public Sector Equality Duty, already make clear that advocacy should be commissioned to meet the needs of diverse communities.⁹³ Where this is not happening, commissioners should be held to account. This could be done via the Organisational Competency Framework, further details of which can be found in 'The experiences of people from ethnic minority communities'.

Relationships with other advocates

Finally, the Review considered the many forms of statutory and community advocacy, and how they relate to each other. The IMHA should be recognised and commissioned as the most appropriate form of statutory advocacy for mental health inpatients, but advocates and providers must be aware of the overlaps with other forms of advocacy. This is particularly important for groups such as children and young people and those with learning disabilities or autism, who are particularly likely to have multiple advocacy entitlements.

Although we are not recommending this is a statutory duty, we do think that, as much as possible, the availability of peer and/or community advocacy should be substantially increased to support individuals in need of mental health support in the community.

⁹³ Code of Practice, paragraph 6.7, p.55; Mental Health Act 1983 (Independent Mental Health Advocates) (England) Regulations 2008; and Public Sector Equality Duty.

Conclusions

Our recommendations will ensure that more patients in hospital, have access to the benefits of advocacy, whilst addressing concerns for all patients around access, eligibility, and the quality and commissioning of advocacy services by local authorities. Advocacy enables supported decision-making by vulnerable people, some of whom may lack capacity and would not otherwise be able to participate in decisions. Enhancing access therefore moves closer to the ambition of the UNCRPD in supporting inpatients to exercise their rights.

We have heard conflicting views around the issues of training, accreditation, standardisation, accountability and regulation of advocates. On one hand, extending this to advocates will bring them in line with other mental health professionals. On the other hand, it might interfere with what some people think is the true power of advocacy, that it is not a profession. The inevitable loss of informality and diversity that comes with professionalism and regulation, may remove the very characteristics that give advocacy its particular value. It is beyond the scope of the Review to make recommendations on this issue, however, and we recommend a full consultation.

Similarly, it is clear that there are many potential overlaps and gaps between the entitlements and approaches of different forms of advocacy. Whilst this is also beyond the scope of this Review, we believe there would be value in the Government thoroughly reviewing the legal frameworks, commissioning and ultimate purpose of advocacy across health and social care.

What we are recommending

- **The statutory right to an Independent Mental Health Advocate (IMHA) should be extended so that it includes:**
 - **all mental health inpatients, including informal patients;**
 - **patients awaiting transfer from a prison or an immigration detention centre;**
 - **people preparing their advance choice documents (ACDs) that refer to detention under the Mental Health Act;**
- **IMHA services should be ‘opt out’ for all who have a statutory right to it, and the CQC should monitor access.**
- **The statutory definition of IMHA advocacy should be amended to cover advocacy around care planning and advance choice**

- **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**
- **Commissioning by local authorities should be strengthened, so that:**
 - **guidelines make it clear that IMHAs are best placed to provide support in cases where there is an overlap with Care Act / MCA advocacy;**
 - **services are commissioned on the basis of existing quality standards**
 - **providers are required to provide quarterly reports to their commissioners about issues and trends, incorporating input from trust staff, families/carers and clients**
 - **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

Patients, their family and carers have a right to complain about the treatment they receive, including care and treatment under the Mental Health Act. The patient's rights to complain are enshrined in the NHS Constitution but we acknowledge this can be difficult.

All providers of NHS mental health services should already have complaints procedures in place. In addition, the CQC can investigate complaints relating to the Mental Health Act (usually once local complaints procedures have been exhausted) and the Parliamentary and Health Service Ombudsman can consider any complaints which do not fall within the remit of CQC.

The NHS Constitution and Local Authority Complaints process are clear that patients should receive support throughout the handling of a complaint; that their treatment should not be adversely affected because they have made a complaint and it is expected that complaints should be viewed as opportunities to learn and to improve services. However, we know that this is not always the case. We have heard that patients' complaints sometimes go unreported or ignored, and that the complexity of the complaints process means that many patients do not even try. The effect of this is that bad practice can become normalised.

We have also heard anecdotal evidence that patients who make complaints are being penalised (for example by having their assessment of risk level raised). In this section, we set out actions that aim to ensure that patients subject to the MHA and their families are able to make complaints and that those complaints are considered.

We think that all NHS and local authority commissioners, providers and staff acting under the MHA should continue to be expected to fulfil their existing obligations under CQC regulations, complaints legislation, the NHS constitution, and follow all other applicable guidance such as NHS Improvement's Well-led framework⁹⁴. This means that they should already:

- Encourage formal and informal feedback as a means of improving services
- Provide an effective and accessible system for identifying, receiving, handling and responding to complaints
- Make sure that patients and their families are aware of their rights to complain and are supported to do so. This includes providing information on making complaints in a variety of formats
- Make sure that patients are not adversely affected by their complaints
- Treat complainants with respect and courtesy
- Abide by the duty of candour and are open about mistakes or failure
- Record all complaints

CQC should also continue to fulfil their statutory duty to consider complaints as part of its monitoring and inspection role as an indicator of services responsiveness and leadership.

Additional duties we are recommending

Given that people who are detained cannot choose to leave hospital, and that there are a number of bodies that deal with complaints under the MHA, it is particularly important that they have clear information on how, and to which organisation, to complain. We are recommending that section 132 of the MHA should be amended to include information on making complaints and that it should be provided to patients and their nominated person in

⁹⁴ See https://improvement.nhs.uk/documents/1259/Well-led_guidance_June_2017.pdf

a clearer way, including through digital means. We also believe that people employed to deal with complaints should have an understanding of the MHA so they are aware of the added urgency of complaints from detained patients. Board papers should disaggregate complaints from informal inpatients versus detained patients so they have a clear understanding of how many complaints relate to those who have been detained and/or treated without their consent.

There are also a number of areas of best practice that we want to encourage. These include improving transparency by involving patients and service users in the complaints process, and publishing anonymised details of complaints on their website (including the actions that have been taken) and actively using patient reviews left through sites such as NHS.uk and Care Opinion (<https://www.careopinion.org.uk/>).

Finally, we are aware of the work of the UK National Preventive Mechanism (UKNPM), a group of organisations which monitors the treatment and conditions of people who are in places of detention (of which CQC forms a part). This was established as part of the UK's obligations under the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) and is focussed on preventing ill-treatment. We would encourage the government to consider putting it on a statutory footing in line with previous recommendations⁹⁵.

What we are recommending

- **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.**
- **Staff dealing with complaints should have an understanding of the MHA so they are aware of the particular impact of detention.**
- **Information going to hospital Boards should be separated between complaints made by patients detained under the MHA and complaints made by informal patients.**

⁹⁵ See, in particular, the Commons Justice Committee recommendation in April 2017: (https://publications.parliament.uk/pa/cm201617/cmselect/cmjust/1150/115004.htm#_idTextAnchor013) at paragraphs para 34-3.

- **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.**

Safeguarding

More needs to be done to ensure safeguarding of patients to protect them from abuse. One of the lessons of incidents such as Winterbourne View is that local authorities have not always been involved to the extent that they should, and that the hospital has not engaged with the safeguarding process. This is despite the fact local authorities have a responsibility under section 42 of the Care Act to investigate any safeguarding issues, including those in private and mental health units in their area and that Trusts have a duty to co-operate with local authorities on safeguarding issues.

What we are recommending

- **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

Under any circumstances, the death of a loved one is a tragic and distressing time for families. However, the death of a loved one detained under the care of the state, especially when it is unexpected or self-inflicted, can be particularly traumatic. People of black African or Caribbean heritage experience disproportionate numbers of deaths whilst in custody and/or mental health care. For example, David “Rocky” Bennett, Sean Rigg and Olaseni Lewis all died as a result of the use of excessive force and prolonged restraint. With this context in mind, it is not surprising that we have heard repeatedly that black African and Caribbean communities have a real fear of death when interacting with the mental healthcare system. In relation to suicide, according to the National Confidential Inquiry into Suicide and Safety in Mental Health⁹⁶, between 2006-2016 in England, there

⁹⁶ National Confidential Inquiry into Suicide and Safety in Mental Health, Annual Report: England, Northern Ireland, Scotland and Wales, October 2018

was an average of 26 suicides per year among detained in-patients, with an additional 13 among those on CTOs.

Family support

Despite it being a time when further distress should be minimised, families often feel that they are not sufficiently supported following a death. Recently published guidelines⁹⁷ from the National Quality Board aim to improve the way NHS Trusts investigate, learn from deaths and work with bereaved families. The principles of the new guidance outline the families' rights to better quality information that is more readily available and delivered in a sensitive manner, a higher standard of bereavement care, and being treated as equal partners in any investigations. The guidance outlines that this should be delivered by a single point of contact.

We strongly welcome this guidance and expect providers to implement them as soon as practically possible. However, we are recommending one additional change to these guidelines - that a family liaison role should be established by providers to implement the guidance for the families of those individuals who die unexpectedly whilst detained under the MHA. This should be done swiftly. We know that when families are well supported at the critical first or early meetings it makes a considerable difference to their personal experience of this distressing process, as well as their satisfaction with the final outcomes of the investigations.

Investigations

It is a legal requirement under the Coroners and Justice Act 2009 for a coroner to investigate any death of a detained patient. However, we have heard from INQUEST and other stakeholders that the way deaths are investigated can be inadequate. In addition to a coroner's investigation, we know that some families want deaths of anyone who dies whilst detained to be independently investigated as a matter of course, similar to the Prisons and Probation Ombudsman investigations of deaths in prison or police custody. We are not recommending that, for now, for two reasons.

⁹⁷ National Quality Board, Learning from deaths, Guidance for NHS trusts on working with bereaved families and carers. First edition, July 2018.

First, in 2016/2017 there were 247⁹⁸ deaths among detained patients, of which most were from “natural causes”. In our view, it would be disproportionate to recommend a further independent investigation for all of these deaths.

There is a stronger case for “unnatural” deaths, such as suicide. However, we need to take note of ongoing activity and progress in this area, which is welcome. This includes the NHS Improvement Serious Incident Framework⁹⁹, which sets out the relevant procedures for the NHS to follow including the commissioning of independent investigations in addition to the Coroner. Furthermore, NHS England requested the Royal College of Psychiatrists to develop a toolkit on dealing with mental health mortality that has been published recently. This is the first-ever national guidance for NHS mental health trusts to ensure ways of improving services are learned from patients’ deaths. The new tool and associated guidance should be given time to bed in before considering whether further changes are needed to make sure all investigations are robust, appropriately independent, and involve families.

Funding for legal assistance

Although we are not recommending an independent investigation in every case, we think that funding should be available for the families of those who have died unnaturally, violently or by suicide whilst detained, to receive non-means-tested legal aid¹⁰⁰. This would be to help families to understand the processes, their rights, and what steps they can take. This would include funding to attend the inquest¹⁰¹, but should also be available to support families immediately after the death of the patient.

Deaths under DoLS/Liberty Protection Safeguards

Section 1 of the Coroners and Justice Act 2009 (CJA) requires a senior coroner to investigate a person’s death wherever (i) the death was unnatural or violent, (ii) the cause is unknown, or (iii) it occurred in state detention. A death where a person is detained under the MHA is automatically considered to be a death under state detention, triggering the need for an investigation by the coroner, whatever its cause. Where the death is unnatural

⁹⁸ Monitoring the Mental Health Act in 2016/17, CQC

⁹⁹ Revised Serious Incident Framework. NHS Improvement. Published March 2015.

¹⁰⁰ We envisage that this would be ‘legal help’ in the first instance.

¹⁰¹ We are aware of, and welcome, the changes that mean that non-means-tested legal aid is now more easily available for the family of a person who died a violent or non-natural death, or took their own life, whilst detained in a psychiatric hospital. For the reasons set out below, think that this should also apply where a person has died whilst subject to a DoLS or LPS.

or violent, or the cause is unknown, an inquest will be held with a jury, who will consider evidence from a broad investigation of the circumstances of the person's death (required to comply with the state's obligations under Article 2 ECHR).

However, following changes to the CJA introduced in 2017,¹⁰² someone who has died whilst subject to DoLS (or, in future, the Liberty Protection Safeguards¹⁰³) is not considered to have been in state detention for purposes of determining that there should be an investigation by a coroner, which means there is no automatic investigation of their death by the coroner. In many cases, this is entirely appropriate, it is simply wrong to consider the natural death of an elderly person in a care home a death in state detention for these purposes simply because they were subject to a DoLS authorisation. But in the case of those in a psychiatric hospital subject to DoLS (or, in future the LPS), it may be far more appropriate to think of them as being in state detention. We are not recommending further amendments to the CJA, but we do think that it is important that all relevant guidance (including from the Chief Coroner, but also the Mental Health Act Code of Practice) make it clear that in these circumstances it should be presumed that the individual is in state detention for purposes of triggering the duty for an investigation by a coroner.

Learning from deaths and serious incidents

One thing that we heard time and again is that where there are lessons to be learned following a serious or fatal incident, these lessons are not being shared nationally so that everyone can benefit, and to prevent similar incidents elsewhere. We think it is crucial that mechanisms are put in place nationally to make sure this happens. We support the recommendation made by the Angiolini report for an Independent Office for Article 2 Compliance, accountable to Parliament, and tasked with the collation and dissemination of learning, the implementation and monitoring of that learning, and the consistency of its application at a national level; we think this recommendation should be reconsidered. We understand that the Department for Health and Social Care has recently committed, through the Ministerial Board on Deaths in Custody, to explore options for how we can learn nationally from Prevention of Future Deaths reports from coroners. We also encourage providers to follow guidance outlined in the National Quality Board 'Learning from Deaths' report. Finally, research¹⁰⁴ commissioned by NHS Resolution published in September 2018, outlines useful learnings related to suicide. We would hope that all such

¹⁰² By the Policing and Crime Act 2017.

¹⁰³ See further section on Deprivation of Liberty: MCA or MHA?

¹⁰⁴ Learning from suicide-related claims: A thematic review of NHS Resolution data. Published September 2018 <https://resolution.nhs.uk/resources/learning-from-suicide-related-claims/>

learning is pulled together continuously and systematically and embedded within the new Mental Health Safety Improvement Programme led by NHS Improvement.

We think that there is a good chance that these measures, taken together, will make a considerable impact in improving the ways in which we investigate deaths, support the bereaved and learn from investigations. For these reasons we are not recommending substantial further changes, in particular automatic independent investigations in all cases. However, this must be kept under review in consultation with the key stakeholders in this area. If, after five years, improvements are not seen, then we recommend that the issue should be revisited.

What we are recommending

- **A formalised family liaison role should be developed to offer support to families of individuals who die unexpectedly in detention.**
- **Families of those who have died should receive non-means-tested legal aid.**
- **Guidance should make clear that a death under DoLS/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

The Review's Terms of Reference asked us to look at the rising rates of detention under the Act and try to understand the cause of this rise. Our literature review has found that although detentions rates in England are about average for Europe, they are rising faster than elsewhere (see Annex C). The number of admissions have been stable over recent years¹⁰⁵, but the numbers of beds have reduced. This means that there are proportionally more people in hospital who are there because they are detained under the MHA, than people who are there voluntarily. This raises some fundamental questions about the nature and purpose of inpatient care in the context of acute care pathways and systems that are beyond the scope of this Review.

As set out earlier in the report (see Understanding Rising Rates) there is no clear single driver for the rising rates of detention, similarly there is there no simple solution to addressing them. If the Government is serious about bringing the rates down, a number of Departments and Agencies will need to work together to develop a long-term approach, supported by better partnership working on the ground.

Research and evaluation

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, it has become clear that this is not possible because of a lack of solid evidence base, we have only, therefore, been able to draw provisional conclusions. Improved research and evaluation is needed to inform the future design, commissioning and funding of services and interventions. This should cover alternatives to detention in inpatient settings, interventions to prevent crisis or the escalation of crisis, and the social factors that lead to crises.

¹⁰⁵ NHS Digital (30 November 2017) Mental Health Bulletin: 2016-17 Annual Report [online]

Evidence is also needed of shorter- and longer-term impact on all types of detention (including aftercare), their duration, and longer-term individual outcomes, taking into account a broad range of outcomes and benefits, including the views and experiences of service users, families and carers.

It is critical that all available evidence is considered in planning future development of mental health crisis services. Trials and high-quality evaluations of innovative service models are desirable, but other forms of evidence such as user-led studies and qualitative evidence should also be considered.

We are recommending that the Government should work with national bodies¹⁰⁶, to fund and undertake a major programme of research into service models and clinical/social interventions and their relationships to rates of detention. This research would be more compelling if it included user-led studies and studies which focus on resources which mental health service users have said they find therapeutic. Service users, families and carers know from their individual perspectives what triggers a crisis and what helps to avoid one.

Alternatives to detention and interventions to prevent crisis or the escalation of crisis

The Review has heard numerous examples of services which have been reported as being extremely beneficial, either in a time of crisis or in preventing crisis. These services are often provided by voluntary sector organisations, not-for-profit organisations and carer and service-user led organisations, and deliver a range of care and support. This includes helping people with, or at risk of developing, a serious mental health issue to address or manage factors which we know can trigger crisis, or limit improvement, such as housing and accommodation, relationships, and debt management. Whilst we would advocate a focus on prevention and supporting people so they do not reach crisis, there also needs to be alternatives to detention to ensure that a consideration of the least restrictive option is possible. AMHPs have a specific responsibility within the regulation of their profession to consider least restriction and alternatives to detention as part of the assessment. AMHPs report that this is improved when they have access to crisis teams and community

¹⁰⁶ such as the National Institute Health Research Mental Health Policy Research Unit, user-led bodies, charities, regional research bodies such as Academic Health Science Networks and Collaborations for Leadership in Applied Health Research, and local systems including the NHS, local authorities and police forces

alternatives to admission, but arranging alternatives to detention can be challenging in areas where partnership working is poor and services are reduced¹⁰⁷.

We think a broad view should be taken when thinking about interventions that can prevent the need for admission. To help this Review the National Survivor User Network (NSUN) conducted a survey of its members asking them to identify support they would have found helpful either when in crisis or at risk of one, or which they would like to see in place. Respondents suggested that the key to recovery is often being heard and understood, receiving a compassionate approach, gaining access to a variety of options and being offered support when reducing/coming off medication. This included access to user-led initiatives and/or initiatives which were non-clinically based, and those which were tailored towards people facing more than one type of disadvantage. We believe such services have an important role to play in the system, but like everything else would stand a greater chance of attracting the attention of commissioners when accompanied by sound evidence.

Ultimately, we think there needs to 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. There is consensus that there needs to be both investment and improvement in community mental health services. Services that are disjointed, and under-funded, lead to more people falling through the gaps and ending up in crisis. People need to be able to access good quality community services quickly and consistently across the country and we need to see the full implementation of NHS England's efforts to address this, including through the forthcoming Long Term Plan. This should also be a priority of the upcoming Green Paper for Social Care, as an integrated approach to crisis services is most effective. Care should be taken to consider the needs of people with learning disabilities, autism or both, to make sure interventions are in place to address their specific needs.

"...I have been sectioned many times since I was a teenager. Every single time, I had asked for help previously and found that there was insufficient community resources to prevent a crisis occurring..." - Service user¹⁰⁸

"...Last summer, my mental health was deteriorating rapidly and instead of being admitted to hospital, I was treated by an Intensive Home Treatment Team who visited me at home or spoke to me 2-3 times a day for 6-7

¹⁰⁷ CQC (2018) Mental Health Act; Approved Mental Health Professional services

¹⁰⁸ Comment from Service User/Carer, Mental Health Act Survey, Centre for Mental Health

weeks until the really rough patch was over. I avoided an admission completely and felt empowered by the whole experience. - Service user¹⁰⁹

We are also aware that alcohol and drug use, and dependence, play a major role in both acute psychiatric presentations and psychiatric ill health. Existing guidance outlines good practice in this area,¹¹⁰ and as a minimum we must seek to ensure that patients are not turned away from mental health services in a psychotic or suicidal crisis because it is perceived by professionals to be substance induced. The reverse is also true- those attending substance misuse services should not be turned away because they have significant mental health problems. The division between health and social care has had a substantial impact on the care of those with what we call “dual diagnosis”.

The Review heard a number of concerns around the disparity of access for different disadvantaged groups, including but not limited to LGBTQ+, ethnic minority communities, people with learning disabilities or autism, and asylum seekers and refugees, who often face barriers to accessing services, especially due to the discrimination they face. Some individuals may be actively excluded, for example because they do not have recourse to public funding or because their problems are regarded as too complex for services to manage. When individuals do access services, those services are often inappropriate for them as they are not equipped to understand their needs, beliefs, backgrounds or culture to be able to provide appropriate care and support. These groups are often facing wider socio-economic disadvantages, which may make them more likely to become unwell, whilst at the same time less likely to access or get the care and support they need. Having a vibrant and varied offer of mental health services is critical to ensuring everyone has access to the support and services they need to prevent crisis and detention.

The government should resource policy developments into alternatives to detention and prevention of crisis. This should include through NHSE's forthcoming Long Term Plan, and the review of social care in the upcoming Green Paper.

¹⁰⁹ Comment from Service User/Carer, Mental Health Act Survey, Centre for Mental Health

¹¹⁰ NICE. Coexisting severe mental illness and substance misuse: community health and social care services. Guidance and guidelines NICE [Internet]. NICE; 2016 [cited 2017 Feb 24]. Available from: <https://www.nice.org.uk/guidance/ng58>; PHE. Better care for people with co-occurring mental health, and alcohol and drug use conditions. 2017 [cited 2018 May 12]; Available from: www.gov.uk/phe; NHS England. Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults – Guidance. 2016 [cited 2018 Jul 17]; Available from: <https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf>

Case study – Look Ahead

University student Lucas¹¹¹ was suffering a crisis triggered by the suicide of a close friend combined with a housing crisis. His risk was assessed as high and he was going to be sectioned to a hospital setting but was instead referred to a place at a Mental Health Crisis House in Tower Hamlets run by Look Ahead, a specialist housing and support provider. The service offers short term accommodation to people experiencing an acute episode of mental ill health - a non clinical alternative to acute hospital admission for those people who are too unwell to be treated at home by the community Home Treatment Team. It works with and is funded by the East London Foundation Trust (ELFT) who provide the clinical support people need for their recovery.

Alongside providing short-term accommodation, the service works with people to offer practical and emotional support to address the reasons for their crisis. This could be anything from poor housing, relationship breakdown or employment issues. During Lucas' stay he was provided with emotional support around his bereavement, practical support around finding suitable housing, and also supported to extend his university dissertation deadline. He called the service a month after leaving to thank staff for helping him take the necessary steps to recovery.

A Crisis House bed costs less than half the cost of a bed on an acute ward.

Tackling the culture of risk aversion

We have heard many anecdotal reports that, over time, there has been a shift in the perception of what is 'acceptable risk' among professionals, which may have contributed to the rise in the use of the MHA. This appears to have been driven by professionals' fears – often arising from court cases¹¹² - that a decision not to detain someone, or to allow them out from hospital whilst under their care, may lead to serious incidents and, at the most extreme, deaths, resulting in a subsequent summons to a coroner's court to defend their decision. Risk is a notoriously complex and emotive area, where lives, as well as quality of life, is at stake. However, as outlined in the foreword, we need to move away from a situation where professionals are overly cautious, where they are ignoring what is often their better clinical and social judgement, out of fear. The ECHR has made clear that

¹¹¹ name has been changed.

¹¹² Such as that of the Supreme Court in *Rabone & Anor v Pennine Care NHS Foundation* [2012] UKSC 2.

overly averse approaches to risk are just as problematic legally as are failures to respond to the needs of individuals. In *Hiller v Austria*,¹¹³ the court emphasised that:

today's paradigm in mental health care is to give persons with mental disabilities the greatest possible personal freedom in order to facilitate their re-integration into society. The Court considers that from a Convention point of view, it is not only permissible to grant hospitalised persons the maximum freedom of movement but also desirable in order to preserve as much as possible their dignity and their right to self-determination.

One example is the concept of risk enablement that is used in social care to challenge this culture of risk aversion and support vulnerable people to live independent lives and take appropriate risks.

Professionals need supportive management, training support and supervision from their organisations and encouragement to adopt positive-/therapeutic risk-taking approaches, in line with the emerging evidence base. To do this will require a concerted, cross-organisation, drive to tackle the culture of risk aversion. We think that health organisations would benefit from liaising and engaging with coroners to develop more closely, over time, a shared understanding of the decision-making processes for detention and the reasons behind them.

The way that risk assessments are carried out, and how the concept of risk is framed, also need a fundamental rethink. Risk changes over time, so assessments need to be frequently redone. Risk assessments are not carried out consistently, and the existing standardised assessment tools are not ideal, because they are designed to fit a generic patient rather than being tailored to an individual and there is little evidence to support their use. There is also a growing view from the suicide and self-harm clinical academic experts that the emphasis needs to be on personalised safety, rather than risk¹¹⁴.

¹¹³ *Hiller v Austria* [2016] ECHR 1028 at paragraph 54.

¹¹⁴ See for example: Chan et al (2016) and Nielssen et al (2017)

What we are recommending

- **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.**
- **Research should be carried out into service models and clinical/social interventions that affect rates of detention.**
- **The Government should resource policy development looking into alternatives to detention, and prevention of crisis.**
- **There needs to be a concerted, cross-organisation, drive to tackle the culture of risk aversion. This will need to include the Chief Coroner, CQC, NHSE, NHSI, 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

Informality and the place of capacity

We think there is great value in patients being able to be treated as an inpatient voluntarily with their own consent wherever possible, in line with the principles of least restriction and patient choice. Our recommendations set out in the Advocacy section can go a long way to ensure 'informal' patients are truly voluntary, well informed about their care and treatment and able to exercise their rights. In order to give informal admission more prominence, we are recommending that section 131 of the MHA is moved so that it sits above sections 2 and 3 of the Act.

To make sure that patients can be admitted informally wherever possible, we think that their capacity to consent to admission must always be assessed and documented. If they have capacity to consent, and do consent, then they can be admitted informally. However, not everyone either can or does consent to their admission. Some people lack capacity to consent to admission; where this happens (as discussed further in 'Deprivation of Liberty:

MCA or MHA' below), the effect of the UK Supreme Court decision in *Cheshire West*¹¹⁵ is that a decision will need to be taken, in almost every case, concerning how to lawfully admit the patient into hospital – either under the MHA or the framework provided by the MCA.

We considered carefully whether we should rule out the use of detention where a person has capacity to consent to their admission, but does not consent. We recognise that there are human rights arguments in favour of this¹¹⁶, but we do not think that those arguments are strong enough for such a large change at this stage. We think that a much greater debate is needed, involving service users, to see whether society is willing to accept the consequences of someone's refusal to be admitted, especially where the consequence is the person's death. The debate also needs to consider whether a person's right to refuse to be admitted is given greater weight than the risk that the person might pose to other people. Perhaps most fundamentally, and as we discuss in more detail in 'the Future Direction of Travel' section, we think that more needs to be known about the role of capacity before moving to a model that hinges on this concept.

The criteria for detention

The current criteria for detention in the MHA are vague, and rely too heavily on whether or not someone has a mental disorder in a way which is inconsistent with developing international human rights standards. The focus should be on the consequences, for the patient and for other people, of leaving the person untreated, and whether those consequences really justify the serious step of depriving the patient of their liberty, or whether care, treatment and support could be delivered in a less restrictive environment. The purpose of detaining should be clear, and should be of positive benefit to the patient.

New criteria for significant harm

Under the current legislation, a person can be detained where it is 'necessary for' or 'justified in the interests of' the patient's health or safety or for the protection of others'. We think this sets the bar too low. Because 'health' encompasses 'mental health', a person can be detained under the Act to avoid any deterioration in their mental health or relapse even if there is no other risk. This may have allowed professionals to become increasingly

¹¹⁵ *P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council & Anor* [2014] UKSC 19.

¹¹⁶ These arguments were also made in a submission from the Equality and Human Rights Commission which, unfortunately, were made at a very late stage in the Review's work.

risk averse; to become too quick to use 'risk' as a catchall justification when they are afraid of consequences that may never happen, indeed probably won't happen. This has not been helped by a lack of provision of community alternatives that could mitigate harm. A major concern for service users is that consideration of risk has become the only way patients are understood and treated; that they are seen:

"primarily as risk entities, rather than as human beings who are in need of compassionate care and treatment"¹¹⁷.

We want to reverse this trend; to use new detention criteria to give professionals the backing they need to take more risks with risk. We believe the Act needs to be more explicit about how serious the harm has to be to justify detention and/or treatment, or how likely it is that the harm will occur. We are recommending that there must be a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person. But our recommendations will not work if they are seen as 'stand-alone'. If the Government agrees, tackling the problem of risk aversion must happen across the board. There is little point in mental health professionals deciding to accept a greater perceived risk if the courts, regulators, media and others do the opposite.

The current criteria allows for any vague notion of risk to be put forwards as grounds; our proposed criteria require that the likelihood of harm is substantial, and that this is backed up by evidence. This will make it harder to detain people in a way that is more aligned with the gravity of the removal of their liberty. Requiring that the potential harm is significant will mean detention will only be permitted in the most serious of cases. We are also proposing that, when making an application for detention under the MHA, the AMHP must clearly state on the application form what specific harm they have identified, and how detention will reduce this, including why alternatives are not available or suitable. Information in relation to the potential harms should also be recorded on the Care and Treatment Plan (see 'a New Statutory Care and Treatment Plan' below) and regularly updated.

"A recovery-orientation is concerned with the development of hope, facilitation of a sense of control, choice, autonomy and personal growth, and the provision of opportunities. Risk management is normally concerned with avoiding danger, restrictions, containment, protection and staff control. These approaches appear to be in opposition (Barker, 2012). In reality, there is much overlap. The challenge is to see how these apparent contradictions can be reconciled and an approach to risk

¹¹⁷ Provided by a member of our Service User and Carer Group Service user

assessment and management developed which will effectively and safely support people in their recovery.”¹¹⁸ Risk, Safety and Recovery Briefing

We know that it can be very difficult for a patient to demonstrate they are no longer a risk, but a short-term emergency measure should not turn into an unnecessarily long-term detention. Requiring the details of the risk to be recorded, and updated, will protect patients from lengthy detention on a vague definition of risk, as well as detention that might be unduly influenced by unintended bias, as happens with ethnic minority patients, and in particular black African Caribbean men.

New criteria on availability of treatment

The MHA has never been about detention in its own right, it has always included a requirement for treatment. Unfortunately, as we have heard, there are clear instances where patients are detained but effectively offered no treatment at all. It is unacceptable morally and ethically for this to occur, and yet it does, because a criterion that only requires (in the case of section 3) that “appropriate medical treatment is available” is too weak. We recognise that this sometimes happens because the necessary treatment is not available, but this does not make it acceptable. The weakness of the current criteria stigmatises people with mental disorder and alienates both patients and clinicians from non-mental health areas of practice¹¹⁹.

We are recommending tightening the current criteria so that not only must appropriate treatment be available that cannot be delivered unless the person is detained, but also that the treatment would benefit the patient. ‘Benefit’, for the great majority of patients, would include contributing to the patient’s discharge, and not solely to public safety (although we certainly do not under estimate the importance of this). Consideration must be given to community alternatives, and it must be clear that the person cannot be treated in the community. This should support a greater shift towards treatment in the community, wherever possible.

¹¹⁸ Jed Boardman and Glenn Roberts, “9. Risk, Safety and Recovery”, Implementing Recovery through Organisational Change

¹¹⁹ Eastman N, Latham R, Campbell, Should there be an Explicit Therapeutic Benefit Test Within Criteria for Detention under Mental Health Legislation, British Journal of Psychiatry (in press)

Treatment should be broadly defined, beyond medication, to include elements such as skilled nursing intervention, and psychological therapy. In situations of crisis, it may be reasonable for the main, but not the only, element of treatment to be to provide a safe therapeutic environment for a brief period of time. The original meaning of the word 'asylum' - as a sanctuary or refuge - is appropriate for giving someone safety in the very short term, particularly where in-reach from social workers can protect housing, family and community links. However, the reality is that many wards are far from therapeutic, and it is not enough that the person is literally being kept off the streets. Nor should continuing detention be justified for long periods simply on the basis of the provision of 'general nursing input and self-care planning', and an assertion that the 'ward routine' provides a therapeutic benefit. Our new criteria would reduce the risk of this happening.

What we are recommending

- **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.**
- **A patient's capacity to consent to their admission must always be assessed and recorded, including on the application form.**
- **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.**
- **Detention criteria concerning treatment and risk should be strengthened to require that:**
 - **treatment is available which would benefit the patient, and not just serve public protection, which cannot be delivered without detention; and**
 - **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.**

We are not recommending any change to the requirement for the patient to be suffering from a mental disorder. Nor, as discussed further under 'People with Learning Disabilities, Autism or Both' are we suggesting that the definition of mental disorder be amended for people with learning disabilities, autism, or both.

A STATUTORY CARE AND TREATMENT PLAN

It is central to our recommendations that detention, beyond a very short period of time, is only justified when there has been a comprehensive assessment of, and plan for, the needs and wishes of the patient, the options available to meet those needs, and the route towards discharge. We are recommending that a statutory care and treatment plan (CTP) is developed soon after the point of detention, which should evolve at each state of the process. This should be the responsibility of the Responsible Clinician (RC).

Where someone is in crisis, and it is not clear what treatment they need (i.e. when a person is detained for assessment under section 2 MHA - detention for assessment and treatment), the initial care and treatment plan may be brief, setting out the known needs and wishes of the patient, as far as they can be established (including where they are recorded in an ACD), the aims of the assessment and treatment during detention, any proposed timescales before improvement might be expected.

Initially, the care and treatment specified in the plan could include giving someone brief respite, the value of which is often overlooked. But during the assessment period, the plan should be developed, so that by the time of a long-term order being imposed under section 3, there is a clear account of why detention is needed and what it seeks to achieve. The plan will continue to develop during detention and should be updated before renewals of detention periods, and appeals to the Tribunal. Increasingly it will focus on how to support the ending of detention and the aftercare that should be in place on discharge.

The plan should be wide ranging, but should set out:

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

- We recognise that the components in this list are already good practice, and will pose no problem at all for many multi-disciplinary teams, but our feedback and evidence suggests that this is not always happening. A legal requirement to include these elements should encourage those applying for detention to think more specifically about the least restrictive way in which the patient can be treated. Not only will this set out what the patient can expect, it will help the Tribunal to consider whether detention is justified.
- We understand that the clinical team will not be able to direct services for all areas of unmet need, or the plan for discharge, but they should be able to set out their expectations within the CTP (this should be linked to the Statutory Care Plan recommended under 'Care Planning and Aftercare'). This should help clinicians with the additional help of the Tribunal (see Challenging Detention section) to lever in the services that they think the patient needs.

Timescales

For both a section 2 and a section 3 detention, a comprehensive CTP should be in place within seven calendar days, and should be signed off by the responsible clinician on behalf of the treating team. The CTP should be reviewed by a clinical director or delegated officer at fourteen calendar days to ensure that it is appropriate, and is being adhered to. This will focus the minds of the treating team to assess the patient quickly and, wherever possible, to discharge them as soon as they are well enough to leave.

the CTP is not intended to increase the burden on professionals. Our proposals reflect the kind of good care planning which we believe should happen anyway, and we are aware that in many places it does. But sadly not all. We don't think there should be an overly bureaucratic process to complete the plan in detail during the initial intervention, when the full picture may not be clear. We are aware that this is what happened after the introduction of the Care Programme Approach (CPA) – and we wish to avoid this.

Tribunal review of the Care and Treatment Plan

We are also recommending that the Tribunal scrutinise the CTP during each application for discharge. As part of that we anticipate that the Tribunal will listen to any concerns the patient has with their CTP and will take this into account when deciding to discharge. Where the Tribunal has concerns, it would be open to the Tribunal to adjourn proceedings (using its current case management powers) while the hospital where the patient is detained is asked to address these concerns (but they would not be able to direct the hospital to change the plans). These powers are in addition to the proposed new power for a patient to appeal a specific treatment decision before a judge of the Tribunal (see 'Challenging a Treatment Decision' above).

Conclusions

The new CTP is a cornerstone of our Review. It will deliver on all four of our key principles:

Choice and Autonomy – the plan must set out how the wishes and preferences of the patient, and their families and carers, have informed what is in the plan. Any ACD or decisions in relation to treatment must form part of the treatment plan, or if they are not, the RC must state the reasons why this is not the case

Least Restriction – the CTP requires the RC to set out the least restrictive way in which treatment can be delivered. By also requiring that the compulsory treatment elements are set out alongside the non-compulsory treatment, the CTP will ensure detention is really needed for the treatment proposed; and that the focus is first and foremost on achieving sufficient recovery for discharge, rather than complete recovery. the CTP should include wider steps that will help a patient to move forwards, such as trial leave, or transfers to another hospital. Frequent reassessment of the specific risk posed will mean that the level of restriction is always under review.

Therapeutic Benefit– the CTP will cover the range of health and care needs that the patient has and will not be restricted to medication. Review of the CTP by the Tribunal will keep treatment plans focussed on the benefit that this treatment will bring to the patient, and how this will help them to become well enough to go home. The Tribunal will also be able to query why the listed unmet needs are not met, and determine whether, if these needs continue to be unmet, they will need to consider discharging the patient (on the basis that treatment is not available and so the detention criteria are not met). The requirement to include what services the clinical team believes are required for discharge, from the outset, is a step change in our current approach which will help to prevent patients leaving without proper discharge planning and effectively falling off a cliff edge.

The Person as an Individual - the CTP should capture specific individual, cultural, religious or other treatment needs.

What we are recommending

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

LENGTH OF DETENTION

There was considerable favour amongst stakeholders for shortening the periods of detention. We considered the proposition in the Interim Report that section 2 and section 3 be merged together, but this raised concerns among some stakeholders that a merge might result in an increase in the maximum initial period of detention for patients currently detained under section 2 who are often discharged well before the 28 day deadline. We also think that sections 2 and 3 were designed to reflect two distinctly different situations (section 3 for where it is clear what treatment a patient may need, for example because their admission is part of a well-known pattern, section 2 for when it is not), and that we should take steps to bring practice back to the original intention (see 'Overuse of Section 2' below). So, on balance, we decided to keep the two separate sections of the Act, but to suggest changes that help to ensure they are used as originally intended, whilst strengthening safeguards across the board.

The main driver for our proposed changes to section 2 and section 3 are to ensure that patients are not detained for longer than is absolutely necessary. We heard that consideration of discharge often comes later than it should or could, and that this is sometimes only prompted by a looming Tribunal hearing or a section renewal deadline.

Section 2 Detention for Assessment and Treatment

We think that section 2 should be significantly recast so that there is more focus on assessment to determine whether or not a longer period of detention is needed. Requiring the RC to develop the CTP within 7 calendar days will mean the justification for continued detention will be re-assessed in the first week. The CTP must be reviewed after 14 days by a Clinical Director or delegated office. This can be part of the existing medical scrutiny process and at that point the CTP should be comprehensive enough so that either:

1. the patient can be moved to a section 3 detention for treatment with a clear account of why detention is needed and what it seeks to achieve;
2. the patient can be discharged (if they have not already been); or
3. clear reasons are set out why an extension, for a maximum of 14 days, for further assessment is needed.

We do not think that there should be a cut-off point of 14 days for the patient to be able to make an application for discharge to the Tribunal. We believe the patient should be able to apply to the Tribunal for a discharge at any point during a section 2, but we realise that if they do so after 21 days, the hearing is unlikely to take place before the patient is either discharged, or placed on a section 3 detention. We are therefore recommending that the patient applies within the first 21 days, and the patient, as well as their NP or INP, should be made aware of this deadline.

Overuse of section 2

We are concerned that section 2 is used too often for patients who are well known to services, and who are not realistically in need of the full assessment required for someone who is not. Overuse of section 2 can disadvantage patients, in particular by denying them rights to aftercare under section 117. It also puts a substantial burden on Tribunals because of the limited window of time that there is to list an appeal against detention under section 2. And this burden has been steadily rising - section 2 appeals now comprise 34% of the English Tribunal's workload (May 2018). This has increased from 24% in 2010¹²⁰.

¹²⁰ In 2012/13 there were 26,451 new detentions under section 2, in 2015/16 there were 36,305 detentions, this represents a 37% increase in new detentions over this period.

We feel that detention timescales will be likely to be reduced if people get the treatment they need in a co-ordinated and planned way.

We think that section 2 should only be used where it is truly necessary to assess someone. Section 2 should not be used because it is perceived as the least restrictive option, and we believe our changes to section 3 mean that this argument no longer holds. We are recommending that the Code of Practice should be amended so that, where the AMHP is aware that 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 since they were previously detained under a section 3¹²¹. We are also recommending that the Code of Practice makes it clear that section 3, rather than section 2 should be used when a person has already been subject to section 2 within the last twelve months.

We are aware that this change could lead, in some cases, to people potentially being at risk of a longer detention, under section 3, if proper safeguards are not put in place to make sure patients are not routinely held until near the end of the maximum period of detention allowed. This should not happen if the statutory CTP is introduced. That is because the CTP will require a clinical review at 14 days (at the latest), and part of this Review will be to determine whether detention should continue. We are also recommending that the RC, together with the AMHP, is required to 'certify' to the Tribunal before the hearing data that continued detention is still justified. We would expect the Tribunal and the CQC to look in to any circumstances where patients were regularly being discharged just before a section 3 hearing, or just before the detention period expires.

Section 3 Detention for Treatment

In some cases the patient may be known to services, and it may be that patient, their family or the clinicians know what they need to do to get the patient out of crisis and in to recovery. For this reason we think we should keep the section 3 in the Act, on the basis it would be possible to establish a sufficiently robust CTP without the need for a section 2 assessment. But, we do think that the current length of detention periods in the first year of section 3 are too long, particularly for up to 6 months in the first instance. We are recommending that the first period of detention be halved so that it is for up to a maximum

¹²¹ In other words we think that the same principle should apply as applies where a patient has been discharged from the MHA by the tribunal, following the decision of the House of Lords in *R (von Brandenburg) v East London and the City Mental Health NHS Trust & Anor* [2003] UKHL 58.

of 3 months, renewable for a further 3 months, then a further 6 months, making three detention periods in the first year. Detention should then be renewable at annual intervals.

But we are still concerned that there may be some patients who, for some reason, are only properly considered for discharge during preparation for a Tribunal hearing. Statistics show that this currently happens in 17% of section 3 cases where the discharge is within 48 hours of when the hearing is scheduled. This is inappropriate, breaches the rights of the patient, and leads to a waste of Tribunal resources that cannot be redeployed at such short notice. We believe this would be prevented by requiring the RC and the AMHP to certify the continuing need for detention 10 days in advance of a hearing under section 3. We would expect the Tribunal and the CQC (HIW in Wales) to look in to any circumstances where patients were regularly being discharged just before a section 3 hearing, or just before the detention period expires. We believe that length of stay is reflexive – in other words it is influenced by the time frames under which people can be detained before a safeguard “kicks in”. We think that the tendency for some RCs to discharge a patient shortly before a hearing is proof of this.

Availability of beds

We heard from AMHPs that there are occasions where someone is assessed as requiring detention, and the order is made, but there is a delay while a bed is found. This can go on for days, whilst the patient is at home and at risk.

Although CCGs and Local Health Boards in Wales are required under section 140 MHA to make arrangements to provide beds for urgent situations, the concept of ‘urgent’ is not defined in the Act and we could only find a small number of examples where local authorities and CCGs had effective arrangements under section 140. We heard that this can mean AMHPs are unable to find a bed, or they have to delay assessments while private provision is arranged many miles away. We are recommending that a maximum time limit is introduced for an application for detention, so that the urgency of the situation becomes clear. The MHA Code of Practice asks local authorities, providers, NHS commissioners, police forces and ambulance services to have a joint policy for admissions in their area, and this should be followed so that every area has a plan in place to deal with situations where a bed cannot be found.

What we are recommending

- **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**
- **The Code of Practice should make it clear that section 3, rather than section 2, should be used when a person has been already subject to section 2 within the last twelve months**
- **The detention stages and timelines should be reformed so that they are less restrictive through:**
 - **introducing a requirement for a second clinical opinion at 14 days of a section 2 admission for assessment**
 - **extending the right of appeal for section 2 beyond the first 14 days**
 - **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**
 - **introducing a new time limit by which a bed must be found following an order for detention.**
 - **requiring the responsible clinician and the 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

The Tribunal's current role is limited to determining only whether or not the patient meets the statutory criteria for detention. The Review heard from service users and carers that they would like greater access to the Tribunal, and that they want the Tribunal to have greater powers¹²². We also heard from a wide range of stakeholders, including service users and members of the Tribunal judiciary, that they would also like the Tribunal to have more powers. Members of the judiciary felt that when they do not agree to discharge, they would like to be able to make other changes to reduce the levels of restriction the patient is under, but their hands are tied. Patients felt that they would like the Tribunal to be able to hear their requests for leave or transfer to a lower level of security.

We are aware that other jurisdictions, including Scotland, operate a system where detention (and in some cases treatment) is authorised from the outset by a tribunal. At the moment, our Review has found no evidence to suggest this reduces detention rates. We are also mindful that holding the Tribunal at the outset is easier in smaller jurisdictions, or countries like Germany, which have very differently structured judicial careers (for example, where judges at a level more junior than ours carry out most of these duties). In the circumstances, we do not think that the very substantial changes that would be required to make the Tribunal an authorising, as opposed to a reviewing body, are justified.

Our proposals would, however, enable the Tribunal to do more than just determine whether a patient should be discharged through giving them the power to make changes to the levels of restriction the patient is subjected to. We are also making recommendations that mean there are more opportunities for a patient's detention to be reviewed by the Tribunal. But at the same time we think that the system and cultural changes we are recommending across the Review will also decrease the overall number of detentions, and, after a period during which the new system embeds, there will be a decrease in the level of need for tribunals.

New Tribunal Powers

We are recommending that the tribunal has new powers concerning leave and transfers to other hospitals. Whilst we are not recommending that the patient is able to appeal to the Tribunal directly for leave or for transfer, the Tribunal will instead be able to consider, when they have decided not to discharge a patient, whether to make directions concerning leave

¹²² The First Tier Tribunal in England and the Mental Health Review Tribunal in Wales

or moves to a lower level of security that would reduce the levels of restriction and give the patient a better chance of being discharged at a future application. The 2003 Scottish Act gave patients a legal right to appeal to the Tribunal against being held at an excessive level of security. This drove the expansion of medium secure services in Scotland and led to significant reduction in the number of high secure beds. There have been no serious public safety incidents as a result of this.

The Tribunal members felt frustrated that they are frequently unable to discharge a patient, not because they think they are not well enough, but because a crucial service is not in place for them in the community. Without that service, the patient would be likely to require readmission, making discharge pointless. This could include accommodation, health and social care. We considered the specific and limited powers that the Special Educational Needs Tribunal¹²³ has to direct service provision, and we want the Tribunal to have similar powers to unblock services in the community which are preventing a patient's release. So we are recommending that the Tribunal has a limited power to direct that treatment and care be made available in the community, if it is clear that, without these services, the patient would have to remain detained in hospital. This would be supported by our recommendation Joint working between NHS and Local Authorities' that local authorities and CCGs work together to facilitate discharge. We envisage this will reduce the numbers of people in very long-term detention, and particularly those with learning disabilities, autism or both.

Tribunal judges told us that they sometimes come across examples of breaches of human rights in relation to treatment and care (for example, unjustified use of solitary confinement). We think the Tribunal should be able to refer these kinds of cases to the CQC (or the HIW in Wales) so that it can investigate the circumstances and, in particular, any systemic issues that they might want to bring to the attention of the wider NHS.

We also think it would be helpful if the Tribunal was provided with performance information for their local providers. This could be pulled from the information the CQC collects, or monthly returns to NHS Digital. It might include data on the average length of stay for each facility, information on staff skills/training, incidents of violence, and patient experience scores. This will help them to understand the context of service provision, and what is available for the patient.

¹²³ Which sits in the same Chambers (in England) of the First-Tier Tribunal as does the Mental Health Tribunal.

New rights of Access

As we set out later in the report (under 'Hospital Visitors') we are recommending removing the right to discharge via a 'hospital manager hearing'. In response we are increasing the rights of access to the Tribunal.

In line with the proposed changes to the detention periods under a section 3 above, we are proposing the patient has one right of challenge to the Tribunal in each period. If our earlier recommendation to reduce the detention periods in the first year so that they are 3 months, 3 months and 6 months consecutively, that would increase the current number of challenges a patient can make in the first year from two to three. But we are also concerned that there may be a change in circumstances after the patient has used their right to appeal which may mean detention is no longer justified. In order to make sure the patient does not have to 'wait it out' to apply during their next detention period, we are recommending a new power for SOADS and the CQC to refer the patient to the Tribunal, if they become aware of a material change in circumstances that makes re-consideration by the Tribunal appropriate¹²⁴. We propose a judicial filter – a Tribunal Judge should look at the application on paper and determine whether a change in circumstances has occurred, and put those cases forward for a hearing. This would expand, but not replace the current powers of the Health Secretary under section 67 of the Act.

We have also been concerned that some patients may stay in detention, or on a community treatment order, for too long because they are not capable of making an application to the Tribunal, and it may be some time before anyone considers whether or not their detention is still justified. To stop this from happening, we are recommending the creation of a new statutory power for IMHAs and Nominated Persons to exercise the patients' right to apply on their behalf¹²⁵. This would occur where there is reason to believe that the patient would wish to apply for discharge but lacks the capacity to bring a challenge.

In order to make sure no-one slips through the net, despite the safeguards we are recommending above, we want to increase the frequency of automatic referral to the Tribunal which would kick in where a patient has not applied, or had an application made on their behalf in the first 4 months of detention, then at the first anniversary of their detention, and annually thereafter. The full Tribunal panel should consider the referral,

¹²⁴ This will be in addition to the CQC's existing ability to ask the Secretary of State to make a reference under s.67 MHA 1983 in relation to civil patients.

¹²⁵ This would be separate to the existing power that nearest relatives have to bring their own application, which we think should remain a power for nominated persons

unless the patient has specifically requested a 'paper hearing' (where the judge comes to a decision based on paper submissions without a face to face hearing) because they do not want to take part, and the Tribunal is satisfied that the patient has capacity to make that request.

If the person does not want this automatic referral to take place, and has capacity to make this decision, they will be able to ask the Tribunal not to determine the application at all; if that happens the Tribunal should retain the discretion to hear the application.

Tribunal Procedure

We are recommending that Tribunal procedures are amended to enable decisions about the progress of an application, for example the consideration of whether a change in circumstances warrants a further Tribunal hearing, to be made by a single judge. However, we think all substantive decisions should continue to be taken by a full Tribunal panel¹²⁶. Any future reforms to tribunal composition should proceed on the basis of full consultation and consideration of proportionality, the interests of patients and access to justice. We are also recommending that a regular forum is created where the Tribunal Service and the Royal College of Psychiatrists can get together to discuss technical and procedural improvements to support both services to be more effective.

Conclusions

We have worked closely with the judiciary to develop our recommendations. Tribunals are a vital safeguard, but increasing their workload will mean additional resources are needed, and we have not been able to properly model the costs and benefits of our recommendations. We suggest Government undertakes a full impact analysis and publishes this alongside any future consultation so that there can be an informed debate about the level of investment in Tribunals, alongside the funding of other recommendations in this report. We realise that it would be possible to give some of the powers that we recommend giving to Tribunals to other independent bodies. But, as there are no other bodies that are sufficiently independent, or that have the necessary powers to take action on behalf of patients, we kept returning to the Tribunal. In future, if the Government does consider a much broader reform that fuses mental health and mental capacity legislation

¹²⁶ Whilst the Review was ongoing, the Tribunal Procedure Committee consulted upon, but ultimately did not adopt, a proposal to move to single-judge hearings in certain cases in England.

together, it might also want to consider how, and by what body, the legislation should be overseen.

What we are recommending

- **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.**
- **Where the Tribunal believes that the 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).**
- **Tribunals should be given performance information by their local providers.**
- **A statutory power should be introduced for IMHAs and Nominated Persons to apply for discharge to the Tribunal on behalf of the patient**
- **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.**
- **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.**
- **For part III patients, automatic referrals should take place once every 12 months.**

DEPRIVATION OF LIBERTY: MCA OR MHA?

A person can only be deprived of their liberty by a legal process. Both the MCA and the MHA provide different legal frameworks to treat someone without consent, and to deprive them of their liberty by detaining, or confining, them in hospital. The MCA can only be used where the person lacks capacity to consent to their confinement. Where the MCA is used, professionals must use a set of processes called the "Deprivation of Liberty Safeguards" (DoLS) to authorise detention and protect the patient's rights. At the moment, if a person has capacity and is objecting to their admission or treatment for mental disorder, the MHA must be used because they are being compulsorily detained against their will. However, it is unclear which framework to use if a person lacks capacity and does not appear to be objecting. As result, either the MHA or the DoLS can be used and this decision varies depending on who and where the decision is being taken. It is unhelpful to have two different options for the patient who cannot consent but is also not objecting. The patient is facing a lottery between two different legal positions. Whilst at first it may be attractive to

use the MHA because, generally, it is considered to have greater safeguards than the MCA, it is also extending the reach of compulsory powers.

The 2014 Supreme Court decision in *Cheshire West*¹²⁷ confirmed a much wider definition of a deprivation of liberty than had previously been understood to apply. This means that, when a person is unable to consent because they lack capacity, their admission to hospital for assessment or treatment will almost always be a deprivation of their liberty. Criticism of DoLS themselves and the consequences of the decision in *Cheshire West* led to a review by the Law Commission¹²⁸. Following this, the Government introduced the Mental Capacity (Amendment) Bill into the House of Lords in July 2018 to bring about urgent reform. The Bill would replace DoLS altogether with a new scheme called the Liberty Protection Safeguards (LPS). As the Bill will not be enacted before we conclude the Review, we are setting out what we consider the correct approach to be, even if that means further amendments to the MCA will be needed in the future.

We want to take use of the MHA back to the position that it can only be used for people who are obviously objecting to treatment. We do not think the MHA should be used simply because someone lacks the capacity to consent to their admission. We have been particularly concerned to hear that the MHA has been used, at least in some cases, because it is easier to use than DoLS¹²⁹. We have also been concerned to hear of significant numbers of cases where the MHA has been used for patients with dementia because of doubts or disputes as to whether the patient is objecting to their admission. Whilst this cannot be confirmed with the data available, the CQC did observe an increase in the numbers of those over 65 being detained under the MHA¹³⁰. In one older adult ward that the CQC visited, the increase being from 15% to 85% between 2013/4 and 2016/7.

The dividing line between the two Acts

We are recommending that the law¹³¹ should be amended so that only the MCA framework (DoLS, in future the LPS) can be used where a person lacks capacity to consent to their admission or treatment for mental disorder and it is clear that they are not objecting.

¹²⁷ *P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council & Anor* [2014] UKSC 19.

¹²⁸ Law Com No 372, *Mental Capacity and Deprivation of Liberty* (March 2017)

¹²⁹ See also here the discussion in the section on the case for change.

¹³⁰ https://www.cqc.org.uk/sites/default/files/20180123_mhadetentions_report.pdf

¹³¹ Which will be in Schedule AA1 to the MCA 2005 when the Mental Capacity (Amendment) Bill is passed; at present it is in Schedule 1A.

We are aware that ‘objection’ is not always easy to identify, especially in people with cognitive impairments. We are also aware that, whilst it may be relatively easy to determine whether or not someone is objecting to treatment in a psychiatric hospital, it will not be so easy when the patient is in a general hospital but treatment for a mental disorder is being considered¹³². However, as set out above, objection is the term that is currently used in both the MHA and MCA, and is a familiar enough concept not just for professionals, but for anyone. We think it is the right dividing line between the MHA and the MCA and we agree with the statutory definition for ‘objection’ in the MCA which will be maintained in the Bill.¹³³ However, clear guidance will be required as to what objection looks like in practice in both the MHA and MCA Codes of Practice, and what practitioners should do where a person who was previously objecting is no longer doing so (and the other way around).

The amendments to the MCA contained in the Bill would make implementation of our recommendations easier in two ways.

The first is because, unlike DoLS, the key decision-makers for authorising deprivation of liberty under the LPS could¹³⁴ be the same as those for detentions under sections 2 or 3 of the MHA. We hope that means the new LPS process will no longer be seen as more of an administrative burden to complete than the MHA.

The second is through the way in which the LPS would work to authorise the deprivation of a person’s liberty. Amendments to section 4B of the MCA would mean that a person with impaired capacity can be lawfully deprived of their liberty in order to give life sustaining treatment or carry out vital action, either in an emergency, or where the process to get an authorisation under the LPS has been started and the person needs to be deprived of their liberty where they are until it is completed. Where there is genuine doubt as to whether a person is objecting to their admission, it would be possible for the hospital to formally start the process for LPS authorisation whilst they investigated the situation. As long as it is necessary to keep the person there to give life sustaining treatment or carry out a vital act,

¹³² It may be appropriate for Government to reflect on whether, rather than the term ‘objection’, clinicians should consider whether or not admission and treatment would be against the person’s known ‘will and preferences’

¹³³ At paragraph 46, which provides that:

“In determining whether P objects, regard must be had to all the circumstances (so far as they are reasonably ascertainable), including the following—

(a) P’s behaviour;
(b) P’s wishes and feelings;
(c) P’s views, beliefs and values.

(2) But regard is to be had to circumstances from the past only so far as it is still appropriate to have regard to them.”

¹³⁴ The precise identities are not defined in the Bill, but left to regulations.

the hospital would have lawful authority to do so. This window of opportunity will allow any doubts to be resolved so that a proper decision about the MHA or MCA can be made. However, we do not think people should be able to be held in this situation for long periods of time. We are recommending that this deprivation of liberty under section 4B of the MCA could be used for up to 72 hours¹³⁵ whilst it is determined whether or not the person is objecting to admission or treatment. We think that this time-limit should be in statute, rather than in the Code of Practice.

As noted above, our recommendations here had been drawn up on the basis that they would be included in future legislation, rather than the current Bill. We anticipate that some time will be needed to 'bed down' the new LPS arrangements before they could be used to authorise a deprivation of liberty for non-objecting patients lacking capacity. The Government will need to consider the practical implications of the new dividing line between the MCA and MHA, including testing guidance for the Code of Practice, perhaps in pilot areas. That would make it problematic, even if it were possible, for the Government to introduce our proposed objection interface in their current Bill.

We should make clear that our proposed MCA and MHA dividing line will only work if the Government's proposals in the Bill, that an MCA deprivation of liberty can be authorised on the basis of risk of harm to others, are enacted¹³⁶. Otherwise, it would not be possible to use the MCA in the inpatient setting for someone who has impaired capacity, who needs treatment to prevent the risk of harm to others, but who is not objecting to being admitted and/or treated.

¹³⁵ By analogy with s.5 MHA 2005.

¹³⁶ At a very late stage in the Review's work, an amendment was introduced to the Bill in the House of Lords by Baroness Barker which would limit the scope of MCA deprivation of liberty to risk of harm to the person themselves. We anticipate that this was introduced without knowledge of our proposal.

In the Community

Where a person is outside the hospital, but is subject to a 'community' provision of the MHA (for example section 17 leave, a community treatment order or a conditional discharge), then we think, as is the case now, parallel authorisations under both the MHA and MCA should be available¹³⁷. Where this happens, a Court of Protection judge should be 'double-ticketed' as a Tribunal judge so that they can sit 'with both hats on' and can consider both MHA and MCA when a patient wants to challenge their situation.

Deprivation of liberty in A&E

We heard during the Review that there is some confusion about existing powers to hold someone in A&E until an assessment can be carried out which may potentially lead to admission to hospital. This is a particular problem when someone who is at risk of suicide is trying to leave A&E. Not every person who is at such risk has a mental health condition, but, if they do, then consideration must be given as to whether they should be assessed for admission. Until a person in A&E is admitted, they are not a patient and staff cannot use the "holding powers" in section 5 to prevent them leaving. As a result, the police are being called to hospital to use their powers (under section 136 MHA) to detain the person and hold them in a place of safety (in practice this is likely to mean that the police officer needs to stay with the person and prevent them from leaving). This is far from ideal for both the person and the police, and, where the police are able to attend, runs the risk of escalating an already difficult situation for the person.

We did consider extending the existing 'holding' powers for hospitals in section 5 MHA to cover A&E. However, we decided that this would be wrong. People often want to leave hospital not because they don't want treatment, but (as we have heard), because the lack of help they are offered means that they become despairing and unwilling to wait any longer for assessment and potential admission. If we did extend section 5, we would be increasing restrictions on liberty by using the MHA to respond to what are often problems

¹³⁷ with two exceptions. First, we think that if section 17 leave is in place, it is unnecessary to make a person additionally subject to DoLS / LPS as section 17 already provides authority to deprive someone of their liberty outside hospital (including an express power for the RC to put the person in the custody of a named individual under s.17(3)). Second, we think that there is a strong case that the Tribunal should be able to authorise a conditional discharge that amounts to a deprivation of liberty.

of resourcing and the provision of mental health support services in the A&E environment¹³⁸.

Instead, we are recommending that there are two further amendments to the proposed amendments to section 4B MCA contained in the Mental Capacity (Amendment) Bill. As set out above, section 4B MCA would allow temporary deprivation of liberty including, on the basis of emergency. The further amendments are:

1. that section 4B(9)(a) should make clear that it also covers steps being taken to secure a person's life, as there might otherwise be arguments about whether someone could be prevented from leaving in the circumstances described; and
2. where section 4B is being used whilst a (potential) admission for mental disorder is considered, a decision must be taken within 72 hours concerning whether any continued deprivation of liberty is to be authorised under the MHA or the LPS.

The advantage of this is that we are not introducing new coercive powers for people with a mental disorder; as section 4B applies to anyone lacking capacity in any setting.

We recognise that this approach would not address the position where a person with capacity wants to leave A&E. However, we do not think using a legal fix to increase the compulsory powers of the MHA is the right answer to a practical problem relating to good medical and nursing care. As we said earlier (in the section on Mental Capacity and Decision Making), and as the Code of Practice should make clear, clinicians should not rush to conclusions (about whether or not someone has capacity), especially in a busy A&E with a distressed or potentially mute patient.

¹³⁸ Addressed also in the very recently published report of the Healthcare Safety Investigation Branch: Investigation into the provision of mental health care to patients presenting at the Emergency Department (I2017/006).

What we are recommending

- **Only the MCA framework (DoLS, in future the 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.**
- **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**
- **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, and dual authorisation under section 17 MHA and DoLS/LPS should not be required.**

COMMUNITY TREATMENT ORDERS (CTOs)

CTOs were introduced in 2007 as a form of supervised community treatment for people who had previously been detained in hospital under section 3. It means that patients can leave hospital but clinicians are able to impose conditions on them to ensure they continue treatment. The main purpose for introducing CTOs was to improve care for patients thought to be a high risk and so improve public safety (a major concern driving the 2007 Act changes), but they were also intended to reduce the likelihood that someone would be readmitted. About 5,000 people are currently on a CTO, considerably more than the number estimated by the Government prior to their introduction. The latest MHA statistics show that 'Black or Black British' people are over eight times more likely to be given a CTO than white people¹³⁹ compared to their representation in the general population.

Unusually for mental health legislation, there have been three randomised controlled trials (RCTs) studies looking at the use of CTOs, one of which is from England. If success is measured by reducing the numbers of people being readmitted to hospital, the evidence that CTOs have achieved their goal is very limited. The trials provided no evidence for this, but their generalisability was limited because some of the most unwell patients were excluded. Whilst these studies have been questioned they do show that RCT trials can be done. We hope that more RCTs are carried out, alongside other forms of evidence such as user-led studies and qualitative evidence, and not just for CTOs.

¹³⁹<https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2017-18-annual-figures>

Other kinds of trials, such as before/after studies, which are not as methodologically rigorous as RCTs, have been more positive. New large-scale studies are due to report shortly, but overall the academic literature currently does not give much support to the theory that CTOs reduce re-admission¹⁴⁰. It has also been impossible to identify the types of patients who might benefit from being on a CTO. Other evidence seen by the Review also raises problems. We heard from many service users and carers that changing CTOs would be the one thing they would do when reforming the MHA, and qualitative evidence gathering suggests that CTOs are often experienced as coercive and restrictive by people who are subject to them.

But on the other hand, we have heard from service users, carers and professionals that there are a small number of people for whom CTOs represent the least restrictive option. Whilst small in number, especially compared to the approximately 5,000 CTOs in existence, this has raised enough concern that repealing CTOs entirely could have a detrimental impact on some service users. In particular, concerns have been raised around patients given a section 37 hospital order (following commission of a criminal offence) and the role of a CTO to support step down (where there are no section 41 restrictions to enable conditional discharge). We also know that many service users believe that CTOs give them better access to services – as one person told us via Twitter:

“Some people on CTOs see them positively as a way of being certain that they will get clinical input. This reflects poorly on the system”.

We understand this point of view, but we believe that CTOs should only be used where they are the least restrictive option, and not as a loophole to access better services. Otherwise this reflects poorly on the system. Instead we must ensure that there is a greater focus on community services for those with serious mental illnesses. Better community provision, better discharge planning, and a statutory care plan are vital to ensure that no one’s access to care following discharge is dependent on the use of a CTO. This will create a better situation for all service users, and remove perverse incentives to use CTOs. We need to remember that CTOs can be an unnecessary extension of the coercive powers of the MHA into people’s lives, and it is clear from what we have heard they can feel like a punitive rather than therapeutic measure.

¹⁴⁰ PRU (2018) Compulsory Community Treatment to Prevent Readmission and Increase Engagement with Community Care: a Systematic Review and Meta-Analysis [Annex]

The package of reforms we have identified is intended to at least halve the use of CTOs, and make sure they are only used when they are the least restrictive option. However, if within five years of implementation, these reforms do not reduce the use of CTOs, or increase their effectiveness, then we recommend that CTOs are reviewed again with a view to removing them all together. As part of this on-going evaluation government will need to ensure that reducing CTOs does not have the unintended consequence of leading to longer detentions. It is essential that a proper system is put in place to measure the impact of our proposed changes, so that this decision can be taken quickly, including if the evidence base changes significantly so that the removal of CTOs is justified sooner than five years.

We are increasing safeguards at every stage so that decisions are never made by a single professional and requiring a higher burden of proof for their use and continued use. We hope that by doing so, the scope for subjective decision-making and unconscious bias will be reduced significantly. In line with other recommendations to increase the transparency of the detention process, and ‘show the workings’ of those who take the decisions to use the powers under the MHA, we believe the changes we are proposing should reduce the number of people from ethnic minority communities who are placed on CTOs.

As well as reducing the number of people placed on CTOs, we also intend to give greater protection to people subject to them than is currently the case. This includes greater attention to the conditions that can be included within a CTO (requiring that they must have clinical benefit and can be reviewed by a Tribunal) improved access to IMHA outside hospital, and more opportunities to challenge the order.

Making a CTO

We think that it should be hard to restrict a person’s liberty with a CTO. The UK Supreme Court are currently considering whether it should be possible to deprive a person of their liberty solely on the basis of a CTO.¹⁴¹ The Government will need to consider in light of the Supreme Court’s judgment whether CTOs, as they stand, are compatible with the UK’s obligations under Article 5 ECHR, and, if not, what changes are required to make them compatible. Even if CTOs survive this judgement, the case for making them harder to implement than at present, remains compelling.

¹⁴¹ In the appeal in the case of *Welsh Ministers v PJ* [2017] EWCA Civ 194.

The criteria to put someone on a CTO should be updated to align with the new detention criteria, ensuring that the decision is not seen as an easy option. The RC should only be able to propose a CTO (and the second community supervising clinician and AMHP approve- see below) if it is a reasonable and necessary requirement to maintain engagement with services and protect the safety of the patient and others. The evidence threshold for demonstrating previous disengagement in mental health treatment should be increased, and must show that previous disengagement led to significant decline in mental health. This is likely to mean that CTOs will not be used after a patient's first detention in hospital in all but the rarest circumstances. Evidence must be recorded against all criteria. The same threshold should be applied when reviewing a CTO. This will shift the position from what we understand happens at present, namely that the patient has to prove that they will not relapse if they are taken off the CTO. Conditions set as part of a CTO must be justifiable on the grounds of clinical benefit.

In addition, we think that the NP or INP should be both informed about the intention to make a CTO, and able to object to it. This will mirror their powers to object to section 3 admissions. In many cases the NP/INP will have a better understanding of the circumstances the patient will find themselves in when they return to the community, so their involvement will mean decisions about CTOs, and the conditions they contain, are better informed. This also strengthens the patient's voice within the process.

As with the decision to detain, we think the decision to make CTOs should be taken by 3 professionals. This should be two approved clinicians (ACs) – one of whom must be the community supervising clinician for the CTO - and an AMHP.

We believe that requiring whoever will be the supervising clinician in the community to be involved in the initial request will improve the planning and implementation of a CTO, by ensuring good communication between ward and community doctors. It should also help prevent CTOs being made too hastily. For example, we heard of CTOs being made by hospital doctors in order, sometimes to free up beds where there are significant pressures on acute wards.

The AMHP should also meet the patient, discuss the CTO with them, and explain the conditions and recall processes before an order can be made. The AMHP must also consult with both the patient's NP/INP and the community team before the CTO is finalised.

The CTO should be for an initial period of 6 months, renewed for a further 6 months, then for 12 months. Each renewal should again involve two approved clinicians and an AMHP, unless the tribunal has reviewed the order within the last two months. If that is the case, and the CTO was upheld, the community clinician and the AMHP can simply confirm the renewal.

The expectation should be that CTOs end after two years. We would expect the Tribunal to take this into consideration when challenges are brought to them. However, we do not rule out a new application being made after two years. This new application will require current evidence against the CTO criteria, regarding the risk of harm to self or others if no CTO is in place. The burden of proof should also shift at this stage. The key change being that if the individual has not relapsed while on a CTO this will not be sufficient justification for a CTO to continue. In simple terms, we are suggesting that two years without deterioration, readmissions or untoward incidents would entitle the service user to be discharged from the CTO, unless there are other compelling arguments. If a new application is made, as with the initial CTO, patients would have a right to appeal once during each time period, and if no challenge is brought an automatic Tribunal would be triggered.

Whilst we want to see the number of CTOs significantly reduced, and for them to last for shorter durations, we have heard from service user and professionals that they believe CTOs have contributed to service users' long-term stability. It is for this reason that we are not recommending a blanket maximum duration. Government may wish to consider the role of the Tribunal, in what we hope will be the small number of cases where a CTO extends beyond two years, and whether they should have an automatic role to review any new applications for CTOs.

Challenging a CTO

At the moment the Tribunal can discharge a patient from a CTO, but nothing more. We heard from members of the Tribunal judiciary that they would like to be able to change the conditions of a CTO, and we agree. This would allow them to remove certain conditions where they think they are unnecessary (i.e. not of clinical benefit, or disproportionate). The Tribunal would not have the power to set conditions, but where a patient has applied to have their CTO discharged, and the Tribunal refuses the application, the Tribunal would be able to change, or remove the conditions whilst keeping the person on a CTO. This would add a further safeguard against the use of conditions that unjustifiably limit people's rights.

The patient should be able to appeal to the Tribunal once in each period. But, we have heard that some people may not know that they can appeal, or do not have capacity to appeal. As set out in the Advocacy chapter, we are recommending that better IMHA services should be commissioned specifically for people on CTOs. This should ensure those on CTOs are aware of their right to challenge. In line with our approach more generally (see the Challenging Detention section above), we are recommending an increase in automatic Tribunals. If no appeal is made to the Tribunal within each time period there should be an automatic referral. As with detention, the community supervising clinician and the AMHP must confirm 10 days ahead of the Tribunal hearing that the patient continues to meet the criteria, and must have met with the patient to confirm this.

This will prevent patients who do not realise they can apply for discharge, or who lack capacity to apply, from remaining on CTOs unnecessarily. A patient with capacity can either ask that the Tribunal reach a decision without a hearing if they do not want to attend, or, they can ask the Tribunal not to hear the application at all; if that happens, however, the Tribunal should retain the discretion to hear it.

Recall

The current process of recall can be slow, cumbersome and unclear. Many service users are unsure about why and how they can be recalled to hospital whilst on a CTO (adding another level of coercion to CTOs in the way they are experienced). We have heard that the threat of recall is frequently used to get people to take medication, as there is a misconception that this alone can justify recall, rather than there also being evidence of a decline in someone's condition.

The recall criteria should be updated to help reflect the detention criteria and improve the process, for service users, when the power to recall is used. We think there should be a substantial risk of significant harm to the health or safety of the patient or to other persons if the patient were not recalled for the purpose of administering medication. Government should also give serious consideration to revising the criteria which limits only allows recall to services connected to a hospital¹⁴². Instead, it should be possible to recall the patient to other appropriate services (e.g. community services), if this is more convenient to the service user. This should be stated on the order.

We have also heard that there can be long delays in the process after someone has been recalled, for example in sending out notices and finding a bed in the hospital. Professionals cite the ability to recall quickly as a key benefit of CTOs, especially if they can bring someone in before their condition seriously deteriorates. However, if the process does not, in fact, work, then this undermines substantially the rationale for their existence. We recommend that government look in detail at the recall process, to ensure that it improves the experience for the service user, and the professionals involved.

¹⁴² The reference guide sets out that recall is possible to a community building attached to a hospital. We are recommending taking a broader view of what would be deemed as appropriate to allow greater flexibility to tailor the CTO to the individual

Revoking a CTO

There is currently an automatic Tribunal each time a CTO is revoked. However, we have heard that by the time the Tribunal sits the patient is often back in the community on another CTO. To manage the additional burden on the tribunal of the automatic referral for each time period, if no appeal is brought, government should consider removing this automatic Tribunal when a CTO is revoked. For patients whose CTO is revoked and they remain in hospital on a section 3, the additional ability to challenge (as set out in the Challenging Detention section) will be available to them. The new, tighter, detention criteria for section 3 would also be applied.

Other forms of coercion in the community

We are aware that making it harder to place someone on a CTOs could see practice move towards others forms of coercion in the community, such as an expansion in the use of extended section 17 leave or guardianship (section 7).

Guardianship is different from other areas of the MHA in that the focus is on enabling individuals to live as independently in the community as possible. In addition, responsibility for the order sits with the local authority. Guardianship has been falling, with a 78% drop in new cases starting in each year from 2004/05 to 2017/18.¹⁴³

We have not looked at these Guardianships in detail, as they were not identified as a priority during the scoping stage of the Review. In updating the MHA to take on our recommended reforms, government will need to consider on what basis guardianship should be continued. It will need to do so anyway in light of the decisions in the cases of PJ and MM, in which the Supreme Court has been considering the scope of legitimate coercion under the MHA outside a hospital setting. The government should test the future of guardianship against our principle of least restriction; the potential for the disproportionate impact on particular communities; and that the safeguards surrounding guardianship are proportionate to the level of coercion that is permitted under it. In particular, the government will have to consider whether the burden of proof should continue to be on the patient to show the Tribunal that they no longer meet the criteria, as this is now out of line with all of the other types of application. However, as set out in the executive summary, we believe the option of guardianship should still be available where

¹⁴³ <https://digital.nhs.uk/data-and-information/publications/statistical/guardianship-under-the-mental-health-act-1983/england-2016-17-and-2017-18-national-statistic>

the only thing that is required is for the patient to have a 'condition of residence' to live in a certain place.

Conclusions

We are aware that, in the short term, our proposals will increase the workload for the Tribunal and for clinicians. However, we believe our changes will lead to a reduction in the use of CTOs, and so in the longer term there will be a saving in cost and time. If this does not happen, and numbers stay the same, or grow, then, as mentioned above, the Government should consider whether it is then the time to end the CTO experiment.

What we are recommending

- **The criteria for CTOs should be revised in line with detention criteria.**
- **The onus should be on the RC 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.**
- **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 AMHP.**
- **The Nominated Person/ Interim Nominated Person will have the power to object to both applications and renewals of CTOs.**
- **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.**
- **CTOs should end after 24 months, though the RC should be able to make a new application.**
- **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.**
- **If no appeal is made to the Tribunal in each time period there will be an automatic referral.**

- **The recall criteria should be updated and the process should be reformed to make it simpler.**
- **Recall to alternative locations should be considered.**
- **As set out in our chapter on Advocacy, IMHA services should be commissioned specifically for people on CTOs that requires providers to proactively approach the patient and offer their services.**
- **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

Evidence¹⁴⁴ indicates that lower levels of coercion can support good care. But, as set out in our section on service user experience, we have heard of many ways in which restricting a person's liberty on the ward is used to coerce and control them, as well as, sadly, stories of abuse. Coercion - a focus on behavioural compliance, and use of reward-based levers (e.g. for access to leave) - can reduce people to becoming institutionalised in an effort to survive.

Data collection on the use of restraint is inconsistent. But we know that restraint continues to be a routine occurrence on many wards, affecting disproportionately both those from ethnic minority communities, women and girls. This is particularly traumatising when the restraint is pain-based or prone restraint^{145 146}, and can lead to significant trauma for those restrained, as well as for the people that see it happen.

¹⁴⁴ https://socialequity.unimelb.edu.au/__data/assets/pdf_file/0012/2898525/Alternatives-to-Coercion-Literature-Review-Melbourne-Social-Equity-Institute.pdf

¹⁴⁵ Agenda briefing on the use of restraint against women and girls, Agenda, Alliance for Women and Girls at Risk, 2017.

¹⁴⁶ Women in Crisis: How women and girls are being failed by the Mental Health Act, Agenda, Alliance for Women and Girls at Risk, 2018

Use of Coercion

We are recommending the removal of coercive behavioural systems and restrictions that lead to loss of autonomy and foster institutionalisation. An example of this might be using access to family as a lever to get a patient to comply, when it should be the patient's right. Providers of wards should take active steps to create calm, responsive and enabling environments which reduce agitation, frustration and the use of physical restraint and seclusion. We are also recommending that frameworks are adjusted so that they do not include 'blanket' restrictions that take no account of individual circumstances. For example, a general rule that all patients are tested or searched for drugs when they return from leave, regardless of the likelihood of finding anything. Use of restrictions should be recorded and justified with accompanying reasons.

We welcome the new Mental Health Units (Use of Force) Act, otherwise known as "Seni's Law", which will now require mental health units to publish data on how and when force (physical, mechanical, chemical or use of isolation) is used. The Act also requires mental health units to improve oversight and training, and appoint someone to be accountable for policies and the overall reduction in the use of force. We are also supportive of work led by NHS England and NHS Improvement to reduce restrictive practices across all NHS-commissioned services delivering mental health and learning disability care. This includes the National Collaborating Centre for Mental Health's Reducing Restrictive Practice collaborative, which is part of the wider current Mental Health Safety Improvement Programme established by NHS Improvement in partnership with the CQC.

What we are recommending

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

PRINCIPLE 3 - THERAPEUTIC BENEFIT

Nikolas Rose, the influential sociologist and scholar of mental disorders and society, recently wrote that “Undoubtedly, inpatient facilities for crisis care are needed, and in many countries, these are shockingly underfunded, understaffed and quite the reverse of the sanctuary that those in severe crisis need”¹⁴⁷. Whilst we believe the services that are offered in England and Wales are better than can be found in many comparable countries, we know that they are far from ideal, and in need of improvement. A fundamental ethic for this Review is to achieve better and more therapeutic experiences for those who are detained under the Mental Health Act.

We also want to see fewer people in crisis and requiring detention under the MHA. Whilst changes to the Act will reduce the number of detentions by increasing the threshold, this will only lead to better outcomes and experiences for service users if there is also good quality care and support before, during and after detention to help prevent crisis, admission and re-admission.

CARE PLANNING AND AFTER-CARE

The provision of care and services outside of the inpatient setting is complex, with access and entitlements covered by many different legal frameworks and funding streams. Service users with serious mental illness often have different rights to on-going support across a range of services such as those under the Care Act, NHS Continuing Healthcare and personalised budgets. How this is managed and incorporated into care planning varies a lot and depends on local partnership working. It is now normal for service users to have multiple care plans, assessments and teams.

This is even more complicated after someone has left hospital. Section 117 aftercare was introduced in the MHA 1983 to provide a statutory right to care following discharge. This was on the basis that, if the state has taken someone’s liberty away and disrupted every aspect of their life, it owes them some support to get back on track after they are released. The Care Act further amended this to define after-care as services ‘with the purposes of meeting a need arising from or related to the person’s mental disorder, and reducing the risk of deterioration and re-admissions’. Whilst section 117 provision places a

¹⁴⁷ Nikolas Rose; Our Psychiatric Future. Polity Press, 2018., p 182

responsibility upon the health and social care systems, it does not specify who is responsible for what. This means that implementation has been shaped by case law, as local authorities and the NHS have tried to clarify who pays; for what care; in what proportion; and in what locality. We have heard repeated evidence that this lack of clarity causes delays to providing care to the most vulnerable people, and that money is being diverted away from front-line services and spent on costly legal disputes.

However, section 117 does provide access to support and care for people who have been detained. We have heard from service users that they believe they would not have got the same level of care and support without section 117. This is because section 117, as a free-standing right, has a lower threshold (the only criteria is that you must have been detained under specified provisions of the MHA, and that you need specific services under section 117) than other local authority and NHS provided support, which rely on stricter eligibility criteria. We have also heard examples of section 117 triggering access to provision service users should have already been eligible for (e.g. the Care Programme Approach), but didn't get until the statutory duty of section 117 came into play. This causes a problem – on the one hand we certainly do not want to see anyone's access to provision restricted, but equally we want to avoid inequality in the system. Patients with equitable needs informally admitted or admitted under a section 2, who do not receive section 117 support, often receive less support in the community to manage their mental disorder or prevent re-admission. This could be due to eligibility criteria, processes not being triggered or (wrongly) lower levels of care and support being provided. Where it is being commissioned by local authorities, they are also being charged for it.

In addition, there are inconsistencies in the way section 117 is administered. For some people section 117 ensures access to services, but we have also heard of service users having to fight for their section 117 provision. The process to review section 117 provision, and identify when this additional support is no longer needed, varies greatly across the country. For many service users their section 117 provision coming to an end, and a lack of clarity around the process, can be a source of great anxiety and worry. We have also heard examples of section 117 not ending when perhaps it should, as professionals are not clear how to assess if it is no longer required. There are also inconsistencies around what is and isn't covered, with prescription charges frequently raised as an issue where local areas have had to develop work arounds in order not to charge section 117 service users for prescriptions for medication related to their mental disorder, and the requirement for patients to obtain their section 117 medicines from the hospital pharmacy to avoid prescription charges - is both outdated and more importantly adds an unacceptable level of restriction to patients who should be supported to receive all their medicines through the standard routes within the community.

Ultimately, we think everyone living in the community with a serious mental illness should have access to good support services. As the government seeks to improve social care support (through the adult Social Care Green Paper) and NHS support (through the NHS Long Term Plan), priority should be given to making sure that good services are available to all, so that everyone with a serious mental health need receives equivalent support.

But we also believe that, it is right that people who have been detained should have additional support to ensure a successful transition to the community. We would have liked to recommend expanding aftercare to section 2 patients and to informal patients, for limited periods. We would also have liked to recommend aftercare to those subject to DoLS/LPS, where the primary reason for their presence in hospital was for treatment of mental disorder.

Overall this might be fairer, but the only way this could be done, within the existing financial envelope, would be to place tighter parameters around section 117 provision and how long it lasts. That would run the risk of creating further inequalities for those in greatest need.

With reluctance, we have concluded that it would be wrong to address the broader inequality in the system by limiting one of the few positive rights the current MHA brings to some individuals. 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 for everyone to keep them well and prevent admission, especially as we hope to see far fewer people detained in the future. As the wider improvements to the system come in, we hope that stepping back down to the statutory care plan (see below) and the standard community offer will not be seen as a substantial loss of access to services and care, as service users will already be getting the support they need.

The Green Paper for Social Care provides an opportunity to resolve this inequality, within social care that supports better access to health and care support as required. The Green Paper will consult on a future vision for social care and we recognise the vital role that social care provision plays in community mental health care – especially in relation to people's rights under the Care Act 2014.

As part of its wider work on health inequality, the Government should also consider, a fairer approach to prescription charges - reducing or ending them for people with long term serious mental health conditions.

In addition, once community services for people with severe mental illness (SMI) have improved, and there is better access for all, we think the government should seek to rationalise what is currently a confusing set of overlapping and inequitable entitlements to health and social care provision and to reduce the complexity of their implementation for the organisations involved.

The recommendations set out below aim to provide short to medium term solutions to support a more standardised offer, through a single integrated and personalised statutory care plan, and clarify and simplify the aftercare system. This would allow local authorities and CCGs to focus more on working with service users to deliver the care and services they need, rather than wasting limited resources trying to navigate the system and arguing over funding.

A new Statutory Care Plan

Co-ordinated Care Planning should no longer be something that is set out in guidance but should be a statutory responsibility across agencies. We are recommending the creation of a new high-quality care plan with a statutory footing. The Statutory Care Plan (SCP) will encompass existing rights under the Care Act, NHS Continuing Healthcare and personalised budgets (and section 117 entitlements if someone has been detained on an eligible section). The new SCP should follow service users through the system, and incorporate the new Statutory Care and Treatment Plan (see Criteria for Detention chapter) when someone is detained, as well as discharge planning and aftercare provision.

The ongoing COCCAP study at City University of London and the EQUIP study at the University of Manchester both identified the importance of care planning that is co-produced with or led by service users, and based on their needs and wishes. Recent evidence shows that people in mental health services value good care and support planning but often feel they do not receive it¹⁴⁸. The CQC regularly reports that care plans are of variable quality and are not always shared with service users, in 2016/17 3 in 10 (32%) records showed no evidence of patient involvement in care planning, a continuous increase over the last 3 years¹⁴⁹. We have heard similarly that service users are not being supported to make decisions about what their care plan should look like.

¹⁴⁸ <https://www.nationalelfservice.net/populations-and-settings/service-user-involvement/service-user-involvement-in-mental-health-care-planning/>

¹⁴⁹ CQC (2018) Monitoring the MHA

Coordinated care planning across the Care Act, NHS Continuing Healthcare and personalised budgets (and section 117), is very variable and dependent on local partnership working. Whilst local level arrangements can work well, putting care planning on a statutory footing, alongside the other recommendations below, will support a more consistent application, with all service users in contact with community mental health teams (CMHTS), inpatient care and/or social care services have an integrated and personalised care plan, which sets out all their care and treatment needs and entitlements.

The SCP should be strength based, co-produced, personalised and focused on recovery, independence and accessing services. This should include the service user's preferences and wishes, as well as Advance Choice Documents (ACDs). The content of an SCP could range from the very simple, to the extremely complex depending on an individual's needs. We believe having a single document which in a digital age we would hope could electronically move with the service user, could play an important part in increasing transparency in the system, and ensuring service users have more control as they move through the system with their needs being clearly stated. This could also prevent patients having to repeatedly tell different services and institutions about their care needs. NHS England's current and any future proposals to improve community mental health services and to personalise care across health and care settings should bring a timely focus on high quality care and support planning, which the SCP can build on.

Better discharge planning

There should also be improved discharge planning when someone is detained under the MHA. The process of being detained under the MHA, even when carried out with the upmost regard for a patient's dignity and safety, can be extremely disruptive. Housing, welfare benefits, childcare arrangements and work can all be thrown into disarray by involuntary inpatient care. The period immediately after discharge carries a significantly increased risk of suicide¹⁵⁰. Getting the discharge process right, and ensuring a service user has sufficient support and access to services in the community to enable effective discharge and prevent re-admission is critical. We welcome NHS England's intention to reduce follow up after discharge from 7 days to 2 days in light of this.

¹⁵⁰ Walter et al (2018) Suicide Methods and Specific Types of Accidental Death and Fatal Poisoning Among Discharged Psychiatric Patients: A National Cohort Study. *Journal of Clinical Psychiatry*

Good Practice guidelines state that discharge planning should start soon after admission and be a multi-agency process organised and delivered under the Care Programme Approach¹⁵¹. However, service users have reported poor experiences of being discharged¹⁵², often without notice or 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 enough¹⁵³. We do not believe any of this is deliberate bad practice, but is a reflection of pressure on beds, lack of integration across health and social care or lack of available community services.

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. As set out in the Challenging Detention chapter, the Tribunal will scrutinise the Care and Treatment Plan, including discharge planning, and inpatients will have access to an IMHA when discharge planning is being discussed. Upon discharge, the SCP should be updated to reflect the service users recent experience of detention, and any changes in their needs following detention, their section 117 entitlements (if they have been detained under an eligible section of the MHA) and any ACDs - whether updated or created if they did not already have one.

Joint working between NHS and Local Authorities

As we have heard, many service users with serious mental illness have needs that cross health and social care in the community. We are recommending that legislation is amended to include a duty for CCGs and local authorities to work together on care planning before and after detention and to have a simple, fair and sensible decision-making process to decide the best way to support people after detention.

This duty to work together should be supported by a clear statement in the Code of Practice on the purpose and content of the SCP and section 117 aftercare. There should then be national guidance which sets out how budgets and responsibilities should be shared for section 117 aftercare, rather than leaving local areas to develop their own arrangements. Ordinary Residence rules should be aligned across health and social care, based on the Care Act, with additional guidance covering people who have been placed by one area in another area, with provision for financial adjustment for some regions. The SCP should set out clearly who is responsible for what elements of an individual's care,

¹⁵¹ Crisp Report 2016; Modernising the CPA 2008

¹⁵² Mind (2017) Leaving hospital: briefing on discharge from mental health inpatient services. <https://www.mind.org.uk/media/18839049/leaving-hospital-minds-good-practice-briefing.pdf>

¹⁵³ As reported through submissions to the call to evidence and wider engagement activity.

including what is being provided as part of section 117 aftercare. The new national guidance should set out how Local Authorities and CCGs use their current responsibility to review and update section 117 aftercare more robustly, ensuring section 117 supports people to move on and develop post discharge, whilst also ensuring the system is providing long-term care for those who need it. The CQC should monitor the effectiveness of joint working between CCGs and local authorities to deliver the SCPs and aftercare. The CQC should also consider how its future monitoring and inspection of services will be informed by issues with collaborative working raised in this Review, with a particular focus on the access and outcomes for people from ethnic minority communities using mental health service.

We have also received strong submissions in relation to the effect of detention upon peoples housing and the risk of losing accommodation. We recommend that that local authorities' responsibility for the provision of appropriate housing and care packages is clarified, to make sure patients can get back to their community as soon as they are considered 'medically safe for discharge'. This is urgently needed as it is the cause of approximately 50% of delayed discharges in Mental Health Trust provider services. This would be further supported by introducing a 'duty to co-operate' for landlords, mortgage providers, local authorities and health providers when considering a detained individual's housing tenancy. We think that the duty to co-operate should also include legal rights to housing, the provision of housing benefit and housing advice.

Good care planning must be person centred and focused on the individual's needs and wishes, rather than on who pays. We heard that areas that have already agreed to local agreements for joint funding have stopped arguing about who pays, and their professionals are freed up to talk about what matters – the needs of the service user. We have heard requests for a 50:50 split (or a single funding pot) to be recommended across the board. However, we think it is for government to determine whether changes to funding structures are needed. Whilst we have received a considerable body of helpful evidence and data on the use of section 117, we have not been able to get a national view on how much is being spent, by whom and on what, in order for us to be able to assess the impact of a shared funding arrangement. However, we do think the government and NHS England should look at this as a matter of urgency, as part of its wider work reforms for health and social care provision, and NHS England's work to improve community support for people with serious mental illness.

What we are recommending

- **There should be a Statutory Care Plan (SCP) for people in contact with CMHTS, inpatient care and/or social care services.**
- **There should be a statutory duty for CCGs and local authorities to work together to deliver the SCPs.**
- **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.**
- **There should be better access to long-term support for everyone to keep them well and prevent admission.**
- **There should be a clear statement in the new Code of Practice of the purpose and content of the SCP and section 117 aftercare.**
- **There should be national guidance on how budgets and responsibilities should be shared to pay for section 117 aftercare.**
- **The effectiveness of joint working arrangements should be subject to monitoring and review by the CQC.**

HOSPITAL VISITORS

Associate Hospital Managers (AHMs) are local, lay, people appointed by the hospital or trust. They have the power, on behalf of the actual managers of the hospital, to discharge a patient. They usually do this by sitting, as a panel of three, holding 'Hospital Managers' hearings'. Although the MHA does not require them to hold hearings, the Code of Practice does set out guidance for hearings in two situations. The first is where the patient (or certain other people such as the patient's advocate) requests a review of their detention; and the second is when a patient's responsible clinician files renewal paperwork when the end of a detention period is coming up. The practice and procedures around the AHM functions are not spelled out in statute, and have evolved in a haphazard fashion over time. For instance, whilst patients can ask for a discretionary managers' hearing as often as they like, the hospital may have a policy which limits the number of applications that can be made in a specific timeframe.

We heard that there is no national job description or framework for role of AHMs. There is no formal or ongoing training, nor a requirement for updated knowledge on NICE treatment standards. Some areas face challenges in recruiting AHMs that have experience of the ethnicity, culture, age and gender of the patients they are dealing with. Each provider uses different criteria to recruit them, and will give them different tasks to do. For some this is fairly wide ranging, and can include being a kind of ‘critical friend’. In other cases, the Trusts in question felt that any role besides holding hearings would be detrimental to their independence.

We do not know how many hearings take place a year or what the discharge rate is, as there is no nationally collected data. We have heard from a number of service users that hearings are viewed as ineffective because the managers are likely to agree with the Responsible Clinician. We heard that the patient does not usually have a lawyer to represent them at hearings, or if they do, this may be a trainee solicitor who is using the hearing as ‘practice for the real thing’.

We are recommending removing hearings to consider discharge following a request from the patient, as we think this duplicates the role of the Tribunal and does not represent an effective use of scarce resources (for the AHMs, and also in terms of clinical time). As we set out earlier in this report we are recommending increased access to the Tribunal, part of which will replace the AHM hearing.

For renewals, the actual managers of the hospital (rather than the AHMs) will of course need to scrutinise paperwork (in the same way as they do an application from the AMHP to detain in the first place), to ensure that it does not contain fundamental errors. We can see that requiring AHMs to also consider whether the patients continue to meet the criteria for detention could provide a triple-lock, but we are not convinced that this is needed¹⁵⁴. If the government does think that this is necessary, we do not think this needs a ‘hearing’, and we understand that in any case many ‘hearings’ are done on paper without the patient present. We think that the paperwork could be considered, for instance, by a single, suitably trained, manager, or alternatively a clinician not involved in the patient’s care.

¹⁵⁴ Because section 20 MHA 1983 already requires that another person (of a different profession to that of the RC) agrees that the criteria for detention are met before the RC can submit the renewal paperwork. This means it cannot be on say-so of one person, which would be inconsistent with our obligations under the ECHR.

If it is felt that a hearing of some kind is necessary for all renewals, then the government should think about who is best placed to hold it. We do not think this would be a proportionate use of the Tribunal's time and would simply move burdens around the system.

A new Hospital Visitor role

AHMs are a scarce resource, hard-working, and committed to the task of participating in improving the way those with the severest illnesses are looked after. If their discharge hearing function is removed, we think that they would have capacity to take on a new role which would enable them to make the most of these qualities.

The Review has been particularly impressed by the examples we have heard of AHMs visiting wards and making reports to hospital boards about quality of life for their patients. We think that there would be value in replacing the current 'Associate Hospital Manager' role with a new '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, that they receive the treatment that they need, and that their rights are protected. We are recommending that the Government and the CQC work with others to determine what this might look like, perhaps following a consultation.

What we are recommending

- **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**
- **The power of associate hospital managers to order discharge following a hearing should be removed**
- **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.**
- **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

Commissioners and providers need to improve the social environments of wards. We set out, in our Service User Experience section, how the cultures and practices of some wards can prevent provision of a social environment that supports recovery. 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. They should also support patients to keep connected to their communities and relationships outside of the hospital where that is appropriate. Ward culture should promote therapeutic benefit and minimise institutionalisation. Recruitment and retention of permanent staff at the right grades needs to be improved, and with ratios identified to ensure safety, a positive ward culture and the development of meaningful therapeutic relationships.

NHS England's plans to create more acute therapeutic environments should learn from co-produced and service-user-led initiatives. A good example of this is Starwards, a project that encourages low cost, staff led, creative interventions that make significant impacts on wards. Starwards works through suggesting activities to help wards build social communities and improve their provision. Others are community based, like The Dragon Café, a peer-led weekly activity event in London, and the award winning residential Gellinudd Recovery Centre (Hafal) in Wales, which was designed and fitted out with input from service users and is run in partnership with them.

Case Study: Gellinudd Recovery Centre (Hafal)

Gellinudd recovery centre is a hospital in Wales run by Welsh mental health charity Hafal, which provides care for individuals recovering from mental illness. It has been designed and developed to offer the best opportunities to help improve people's health.

Importantly, it is run in partnership with the people who use it. The guests take an active role in planning, evaluating and developing the service, meeting regularly with staff.

Central to the approach at the ward is their Recovery Programme which promotes self-management and a holistic approach. Guests identify their recovery goals in a comprehensive care and treatment plan covering all aspects of an individual's life including social and cultural, work and education, and physical and psychological health.

“Our experience has proved that recovery focused services with an emphasis on co-production mean better outcomes for patients and a reduction in financial cost.”¹⁵⁵

In line with our recommendations for strengthening the patient’s voice and shared decision-making that we set out under 'Choice and Autonomy', ward culture should support a more equal balance of power between the patient and their treatment team. In line with this, the CQC should develop new criteria for monitoring the social environments of wards.

This will only be achievable if there are enough staff, with the right skills. Staffing levels should be sufficient to support, at least, a daily one-to-one session with patients. To achieve this, NHS England and NHS Improvement should drive quality improvement initiatives across the mental health system, placing particular emphasis on levels of recruitment and retention of effective and caring staff.

We emphasise that although we have separated the social from the physical environment in this report, in practice the two overlap and interlink, as do a patient’s physical and mental health needs.

What we are recommending

- **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.**
- **Patients should have a daily one-to-one session with permanent staff in line with NICE guidelines.**

¹⁵⁵ Guide to Gellinudd Recovery Centre, <http://www.hafal.org/gellinudd/>

INPATIENT PHYSICAL ENVIRONMENTS

Detained patients are held and/or treated against their will and are by definition at their most sick and vulnerable. But these 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, because of its negative impact on patient experience. For example, rimless toilets, heavy wipe clean armchairs, hard flooring and bare walls that are easier to clean, but absorb little sound make buildings oppressively noisy. The Equality and Human Rights Commission's 'Adult Deaths in Detention Inquiry' 2015 identified the importance of physical environments in psychiatric hospitals¹⁵⁶.

Poorly designed and maintained buildings obstruct recovery by making it difficult to engage in basic therapeutic activities (getting outdoors or social interaction with others) and contributing to a sense of containment and control. Wards are experienced as cold and impersonal places, that some say are more similar to a prison than a hospital, making a return to the community, with all its everyday stimuli and risks, more challenging. We are calling for a major capital investment in the NHS mental health estate as part of the proposals from the NHS for a multi-year capital plan to support the Long Term Plan¹⁵⁷.

Ward design

We are recommending that physical environments are improved through reviewing the physical requirements for ward design (e.g. the building notes, regulatory standards), and incorporating patients into their co-production. We are concerned that the overarching criteria (the Key Lines of Enquiry) for physical environment provision that is covered by CQC inspections is the same specification used for wards designed to treat physical health. However, it is noted that when they inspect a mental health service, the CQC do use individual assessment frameworks which include specific prompts and guidelines on what a good ward environment should look like. But the CQC's focus on environmental safety (e.g. removing all ligature risks) sometimes conflicts with developing a more therapeutic environment. We are recommending that the prompts and guidelines currently used for inspections in the assessment frameworks specific to mental health inpatient care are reviewed with input from patients and their carers.

¹⁵⁶ https://www.equalityhumanrights.com/sites/default/files/adult_deaths_in_detention_inquiry_report.pdf

¹⁵⁷ that will be considered by government ahead of the 2019 summer Spending Review

Freedom of access

Research in Germany¹⁵⁸ showed that unlocked wards had lower levels of absconding and suicide attempts and had no greater risk of actual suicide than those with locked doors. Government should look at international research when considering estate design, and that wards should be designed so that, as much as possible, there is free access to bedrooms and communal spaces.

Repairs and Maintenance

This needs to be addressed with urgency. Facilities are substandard and worn out. This makes delivery of good care difficult, and there is a clear case that parity of esteem has not been made real. We are recommending that mental health facilities should be brought up to standard. The government and the NHS should commit in the 2019 summer Spending Review to a major multi-year capital investment programme to modernise the NHS mental health estate.

What good looks like

Fixtures and fittings should support independence, social interaction and activity. Any risk- or infection- control measures should be proportionate, and the potential for negative impact on patients and the social environment should be assessed and minimised.

Wards should be acoustically and visually calm, clean and functional, with adjustable levels of light and temperature control. In line with the reasonable adjustment duty¹⁵⁹, adaptations should be provided for disabled people. Wards should also allow patients to feel safe, and, where necessary, provide adaptations that provide protection from sexual and physical assault. Ward design should be co-produced with people of relevant lived experience, including people with learning disabilities and autism and their carers.

¹⁵⁸Christian G Huber et al, 'Suicide Risk and Absconding in Psychiatric Hospitals with and without Open Door Policies: A 15 Year, Observational Study' (2016) 3(9) *The Lancet Psychiatry* 842, 842.

¹⁵⁹ Reasonable adjustment duty, Equality Act 2010

The design needs to incorporate communal and outdoor space that support good quality interactions between staff and patients, whether this is taking place one to one or in a group. Quiet spaces should also be provided that can be used for privacy, telephone calls, visits and meetings. It is important that all existing dormitory accommodation is updated to allow patients the privacy of their own room.

Single sex accommodation

We have heard of many instances where vulnerable patients have been placed on mixed wards, or in rooms where the access is not limited to single sex patients. This has led to serious sexual assaults, as well as to patients feeling unsafe. We are aware of the high proportion of detained patients who have been the victim of sexual violence or exploitation in the past, and this puts an even greater responsibility on providers. We welcome the improvements already identified, and the existing work in this area by NHSI and the CQC. But we think the definition of 'single sex accommodation' needs revisiting to make sure that sleeping accommodation, bathrooms and daytime spaces are genuinely single sex, with optional mixed sex daytime space available. This is particularly needed to make sure children under the age of 18 are safe if they are held on adult wards.

What we are recommending

- **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.**
- **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.**
- **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.**
- **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.**
- **The backlog of maintenance and repairs needs to be addressed so that mental health facilities are brought up to standard**

- **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.**
- **All existing dormitory accommodation should be updated without delay to allow patients the privacy of their own room.**
- **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

Our section on service user experience earlier in this report set out how people's rights are commonly disregarded with lack of access to privacy, contact with the outside world, family and friends and a lack of respect for the essential nature of parent-child relationships. We heard how care and treatment often does not consider patients' needs and strengths relating to their race, culture, identity, disability, their place in communities and experience of discrimination. A failure to see people as individuals, a lack of empathy and a lack of person-centred activities and therapies all contribute to institutionalisation which creates barriers to improved health.

The experience of patients from ethnic minority communities, and in particular black African Caribbean men, indicates that some staff fail to address negative assumptions about the level of risk presented by the patient, which leads them to misinterpret the nature and degree of their illness. This leads to low expectations concerning outcomes for the patient. LGBTQ+ patients also reported being stigmatised and not having their needs addressed. Children and people with learning disabilities and other patients who are vulnerable because of protected characteristics could be more vulnerable to poor care.

"I think there should be more person centred care, more so than blanket rules...It should be individualised to your care with a say on what you're allowed to have and not have" - Service user¹⁶⁰

Recognising individual and cultural needs

Care and treatment should be tailored with the aim of achieving equality of outcomes across the patient community, regardless of any protected characteristics. Reasonable adjustments should be made where necessary to support this, including those based on the patient's communication abilities and preferences. We know that most, if not all, staff are aware of the importance of diversity and protected characteristics, and that they will do

¹⁶⁰ Comment from Service User/Carer, No Voice No Choice, Rethink Mental Illness report, published April 2018

as much as they can to treat people appropriately. However, a lack of cultural competency and a lack of resources (both financial and workforce) means that this can be challenging. To support this, the Organisational Competency Framework being recommended under our section on the Experiences of People from Ethnic Minority Communities - to reduce the inequalities experienced by black African Caribbean patients - could be easily adapted for other groups as well.

We are recommending that the CQC reviews and updates their inspection and monitoring framework. This should include a greater emphasis on improving and prioritising the gathering and evaluation of patients' experiences, particularly from those in out-of-area placements and those who may find it difficult to articulate concerns and fears, which, in turn should promote ongoing improvement amongst staff.

Recognising individual strengths as well as past trauma

Every patient is different, and even where they may share similar experiences, each patient will have been affected in a way that is unique to them. Good care means treating people in a way that takes into account the context of the communities they come from, their lives and past experiences, including trauma and discrimination. These individual experiences can bring particular strengths¹⁶¹ and vulnerabilities and can affect the patient's experience of mental illness, mental distress, treatment and care. The impact of trauma as a defining experience for many patients was raised throughout the Review by service users, and we are aware of, and support, the work of the Women's Mental Health Task Force which we know has promoted a gender informed and trauma informed approach when treating women with mental illness.

Personalised Care and Support

We understand that the NHS, working with partners in local government, is developing an expansion in personalised care and support. This is intended to make sure people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths and needs. This approach takes learning from every day practice within social care, and we understand will be a key part of the NHS Long Term Plan. We hope that this will be developed across inpatient and community mental health services.

¹⁶¹ <https://www.scie.org.uk/strengths-based-approaches/guidance>

Maintaining Contact with Family and the Outside World

No-one needs to be reminded that relationships are crucial to improving health outcomes. However, some of the pressures placed on services, such as the push to reduce length of stay, or achieving more measurable targets, means that this can be overlooked. But the patient's social relationships can easily be disrupted, or severely harmed, during even a brief admission. Maintaining a person's place in their community, for example in school, places of study, employment and social and religious activity, can so easily be neglected. Staff should work with the patient to facilitate and maintain those connections and related activities. Wards should be designed so that they have resources that allow patient engagement in activities that promote and maintain community and social links including creative, physical, social, musical, religious, work and daily living-related activities, and access to digital media and the internet. Nothing can make maintaining links more difficult than being detained far from home and family. So we strongly support ongoing work to end to use of inappropriate out-of-area placements, and this needs to continue until the practice is ended.

Maintaining physical health

We have heard that patients can find it difficult to get help for physical health conditions. We are also concerned about the high number of deaths from natural causes amongst detained patients. We welcome the statement in NHS England's Five Year Forward View for mental health, that 'Patients with mental illness need their physical health addressed at the same time'. But we think this needs to go further. We are recommending that a patient's physical health should be monitored, so that physical illness and conditions (e.g. diabetes and asthma) can be identified and treated. Patients should be supported to manage their ongoing conditions and maximise their potential for self-care and physical wellbeing. Health and Social care commissioners should continue to support providers to provide high quality physical health checks and, where necessary, interventions to people on inpatient mental health wards. Research has repeatedly shown that people receiving inpatient psychiatric care are less likely to receive, and even less likely to attend, invitation for screening programmes such as breast or cervical cancer.¹⁶² Every effort must be made to ensure that physical health screening programmes, such as those likely to be

¹⁶² Werneke U, Horn O, Maryon-Davis A, Hutchinson B, Wessely S, Schnaar A, Donnan A, McPherson K. Screening for breast and cervical cancer in patients with mental illness. *J Epi Comm Health* 2006; 60: 600-605

recommended in the NHS Long Term Plan or elsewhere, do not overlook those receiving inpatient care.

What we are recommending

- **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**
- **Reasonable adjustments should be made to enable people to participate fully in their care, including in relation to communication abilities.**
- **A patient's physical health should be monitored, so that physical illness and conditions (e.g. diabetes and asthma) can be identified and treated.**
- **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

We have heard, particularly from the families of service users, that Tribunal panel members do not always understand the particular needs of patients. This was mentioned most frequently in relation to people with learning disabilities, autism or both. Ideally, we would have wanted to recommend that either the medical or specialist lay member should be drawn from a pool of appropriately qualified individuals for cases in specific areas, including CAMHS; forensic; learning disability; autism; and older people. However, we understand this would be impossible in practice given the small number of specialist psychiatrists. For example, the Tribunal in England already has a CAMHS panel of 110 members to hear approximately 1,000 applications and referrals a year (3% of tribunal workload). It is not possible for them to be present for every hearing. It is even more difficult for Tribunals in Wales where the numbers are smaller.

Training for Tribunals

We are recommending that the Judicial College should develop a system of training for panel members so that they can become 'ticketed' in specialisms including children and young people, forensic, learning disability, autism, and older people. Her Majesty's Courts and Tribunal Service could then keep records of their members and allocate them to appropriate cases whenever possible. Recruitment and training of members should also extend to include expertise and/or knowledge or experience in race relations and anti-discriminatory practice. We accept that this is a medium not short-term goal.

Tribunals should record whether someone before them would benefit from having someone with the relevant knowledge at future hearings. For people with learning disabilities and/or autism, this would help them to be aware that Care and Treatment Reviews should be taking place, and to ask to see them.

Proportionality of decision making concerning protected characteristics

When we started this Review, we wanted to find out what proportion of applications for discharge are made to the Tribunal by patients from ethnic minority communities, in particular black African Caribbean patients, and what are the comparative discharge rates. Surprisingly, we found out that HMCTS do not collect this information. We did discover from the Legal Aid Agency that 19% of the applications made for legal aid for discharge applications were from black patients. It is clear that statistics on ethnicity are needed to help understand the experience of the Tribunal system of patients from ethnic minority communities. We are recommending that information on protected characteristics, and particularly ethnicity, is collected and published by HMCTS on both numbers of applications, and rate of discharge.

What we are recommending

- **Training should be developed for panel members in specialisms including children and young people, forensic, learning disability, autism, and older people**
- **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 ¹⁶³

Profound inequalities exist for people from ethnic minority communities in accessing mental health treatment, their experience of care and their mental health outcomes¹⁶⁴. We know that people of black African and Caribbean heritage are more likely than white British people to come into contact with mental health services through the criminal justice system, rather than via their GP or referral to talking therapies¹⁶⁵. Adults of black African and Caribbean heritage are more likely than any other ethnic group to be detained under the Mental Health Act¹⁶⁶.

We know that racism experienced in everyday life compounds already poor experiences of, and outcomes from, health services.¹⁶⁷ Research has clearly linked health inequalities to racism as well as socioeconomic factors (such as inequalities in housing, local neighbourhoods, education and employment), but previous attempts to address these issues have only been partially successful at best. We agree with the goals and aspirations of the Delivering Race Equality (DRE) programme, for example, but there was a disconnect between the resources needed and timescales available which meant that changes were unsustainable.¹⁶⁸

“Seems [professionals] have to make a special effort to treat us like human beings” – Service user of black African and Caribbean heritage¹⁶⁹

Our recommendations represent a shift in tackling racial inequalities by accepting that the structure of existing systems needs to change gradually to improve overall quality of services. The input of service users, carers and communities is crucial in achieving this change. Our recommendations apply primarily to health and care organisations, including

¹⁶³ We have chosen the term 'ethnic minority' rather than 'Black, Asian and Minority Ethnic' (BAME) simply for the purposes of accessibility and clarity. In reality, however, these terms are often used interchangeably.

¹⁶⁴ Bhui, K., Halvorsrud, K., & Nazroo, J. (2018). Making a difference: Ethnic inequality and severe mental illness. *The British Journal of Psychiatry : The Journal of Mental Science*, 213(4), 574-578.

¹⁶⁵ Bhui, K., Ullrich, S., Kallis, C., & Coid, J. (2015). Criminal justice pathways to psychiatric care for psychosis. *The British Journal of Psychiatry : The Journal of Mental Science*, 207(6), 523-9; Morgan, C, Mallett, R, Hutchinson, G, Bagalkote, H, Morgan, K, Fearon, P, et al. (2005). Pathways to care and ethnicity. 2: Source of referral and help-seeking. Report from the AESOP study. *The British Journal of Psychiatry : The Journal of Mental Science*, 186, 290-6.

¹⁶⁶ <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2017-18-annual-figures>

¹⁶⁷ Williams, D.R., & Mohammed, S. A. (2013). Racism and Health I: Pathways and Scientific Evidence. *American Behavioral Scientist*, 57 (8), 1152-1173

¹⁶⁸ <https://www.mind.org.uk/media/273467/the-end-of-delivering-race-equality.pdf>

¹⁶⁹ Comment from Service User, submission to Independent Review of the Mental Health Act

services commissioned and provided by the NHS and local authorities, but they should be considered equally applicable to wider public bodies including police services and the criminal justice system. High quality services can only be delivered if there is equality of access and outcomes for all. We also heard that many organisations may not be meeting their Public Sector Equality Duty under the Equality Act 2010 and should be supported to do so, in line with the recommendations of the *Is Britain Fairer?* report by the Equality and Human Rights Commission (EHRC)¹⁷⁰.

As well as the ethical reasons for promoting equality of access and outcomes, we believe that there is the potential for significant savings associated with reducing the disproportionate rate of detention of people from black African and Caribbean communities.

A new community-driven Organisational Competence Framework

Our primary recommendation is for an Organisational Competence Framework (OCF) and Patient and Carer Experience Tool to be developed and implemented first by the NHS, but ultimately for rollout to wider public services. This follows the recommendation of the Crisp Commission to identify a clear and measurable set of Race Equality Standards for acute mental health services, which they suggested should be developed to test whether the Workforce Race Equality Standard (WRES) is improving services.¹⁷¹

The OCF will support organisations to fulfil their existing obligations under the Equality Act 2010, in accordance with the Public Sector Equality Duty. It can be used by organisations to demonstrate to the CQC that they are effective, responsive, caring and well-led. The OCF should be a practical tool which enables organisations to understand what steps it needs to take to achieve practical improvements for individuals of diverse ethnic backgrounds. This process requires the involvement of communities from the outset and throughout the development of services. Crucially, the OCF will encourage structural and cultural change to be embedded into healthcare delivery over time, responding to the particular needs of local populations.

¹⁷⁰ <https://www.equalityhumanrights.com/en/publication-download/britain-fairer-2018>

¹⁷¹ <https://www.crisiscareconcordat.org.uk/inspiration/the-commission-to-review-the-provision-of-acute-inpatient-psychiatric-care-for-adults-february-2016/>

We endorse ongoing work by NHS England to develop an OCF for mental health – the Patient and Carer Race Equality Framework (PCREF). We believe that goals should focus on several core areas of competence: awareness, staff capability, behavioural change, data and monitoring, and service development. The OCF will help providers to design services which are more attractive to people at an earlier stage of the mental health system, which will help to tackle the low levels of engagement. The OCF will also direct staff towards having regard to a person’s past and present wishes and preferences and promote respect and dignity. The OCF will help to combat structural factors which lead to disparate outcomes for certain groups.

At all levels, the framework offers an important accountability tool: ensuring Trust boards set a strategic vision to respond to the needs of their patients; allowing regional commissioners to ensure alignment of service provision with wider population need; and, importantly, offering an important benchmarking tool at national level, bolstering wider work such as the Race Disparity Audit.¹⁷² The framework should be underpinned by a system of incentives, levers and drivers, to be tested and evaluated through a number of pilot sites in diverse geographical areas. 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. Ultimately, we want this to be a simple, workable approach that can be readily adopted and welcomed by organisations, as opposed to overburdening them with what could be viewed as a bureaucratic process.

Building on the PCREF, and in line with our ambitions surrounding the increased appropriateness of mental health and care services, local authorities should also be held to account for the use of the OCF – for example, in relation to the commissioning of culturally-appropriate advocacy services.

The OCF would enable any organisation, from any field, to use the voices of users to help them improve access and outcomes for those from ethnic minority backgrounds. Educational institutions, police services, the criminal justice system and other public-sector organisations could all benefit from adapting the methodology of the PCREF and adjusting it to their needs. Together, cohesive action across all interrelated areas of domestic policy has the potential to dramatically improve outcomes for those who use or who are impacted by their services. A similar approach to the OCF could also be used to improve access and outcomes for those with other protected characteristics. The OCF is more likely to be implemented if supported by the by the CQC and the EHRC.

¹⁷² <https://www.ethnicity-facts-figures.service.gov.uk/background>

What does the PCREF mean in practice?

We accept that some will be unclear what difference the OCF will bring about on the ground, and how it will respond to different models of service provision. Building on our terms of reference to address the overrepresentation of ethnic minority individuals in detention, the PCREF we envisage for formal mental health services should offer a practical method of improving the mental health care and services delivered to people of black African and Caribbean heritage. The PCREF will help an organisation, such as a CCG, Trust or local authority to:

1. Identify areas for improvement in relation to matters around ethnicity, especially for those people of black African and Caribbean heritage – this might be on inpatient wards, the rates of CTOs, numbers accessing psychological treatments or getting family therapy;
2. Put in place strategies, interventions and actions to improve overall competence; and
3. Provide a recurring feedback loop to the Board, Trustees, stakeholders and the public to keep them informed of progress.

Critically, user input is central to the design and delivery of the framework – and this sets it apart from other previous programmes.

Culturally-appropriate advocacy

A lack of cultural understanding can make already poorer outcomes worse for patients from ethnic minority communities, and potentially reinforce barriers to earlier engagement with services. Advocates are well placed to help patients voice their individual needs, and can be crucial to establishing a better foundation for appropriate care and treatment. However, we know that generic advocacy support is poor at proactively engaging ethnic minority people.¹⁷³ The provision of culturally-appropriate advocacy is key to reducing additional stresses and anxieties that could exacerbate a patient's mental condition, as well as to support speedier recovery. This is particularly important in redressing the

¹⁷³ Newbigging, K., McKeown, M., & French, B. (2013). Mental health advocacy and African and Caribbean men: Good practice principles and organizational models for delivery. *Health Expectations*, 16(1), 80-104.

balance for individuals of African and Caribbean heritage, who are disproportionately impacted by broader societal inequalities.

In line with our wider proposed changes to the role of Independent Mental Health Advocates (IMHAs), further efforts are required to ensure that advocacy services consistently meet the needs of diverse communities. The EHRC and other sector leaders should help local authorities to understand how to comply with their existing statutory duties, including Public Sector Equality Duty obligations. Voluntary and community sector organisations should be encouraged, and adequately resourced as necessary, to provide meaningful support to people from under-represented groups and smaller communities who come into contact with mental health services.

Culturally-appropriate advocacy is a proportionate approach to help reduce the likelihood of people experiencing mental health services as abusive and that disenfranchised patients have their views heard, recorded and considered, and that dignity is upheld.

Religious and spiritual needs

A fundamental lack of understanding, or even a basic appreciation of different religious and spiritual beliefs, can impact upon an individual's experience of assessment and detention under the Mental Health Act. We know that the provision of multi-faith rooms, whilst available at most hospital sites, does not go far enough to accommodate individual spiritual practices – and even where provision is available, patients anecdotally struggle to gain access. Despite religious need currently forming a part of the clinical admission process, anecdotal evidence points to the fact that records are frequently marked as little or no significant need with minimal justification.

We are clear that patients should experience no barriers to the continued observance of religious or spiritual practices while detained in hospital, and any decisions that mean this does not happen should be clearly justified and documented. As a minimum, we expect locally-led audits of religious provision within proximity of each hospital site, with Trusts expected to encourage access where possible. The CQC should serve a pivotal role in overseeing sustained improvement in this particular area.

In line with wider recommendations concerning advance choice and improved statutory care planning (see 'Making decisions about care and treatment' and 'Care planning and after-care' respectively), religious or spiritual need should be communicated to staff either directly in person or indirectly via for example an ACD. Due regard to advance choice is particularly important in cases where patients have been assessed and deemed to lack capacity to make a decision.

Cultural understanding in staff

“With regard to BME [ethnic minority] patients, I think [a] lack of cultural awareness among mental health staff is a major issue.”¹⁷⁴ – Service User

The NHS Workforce Race Equality Standard (WRES) programme is taking steps towards addressing the issue of underrepresentation of certain ethnic minority groups comprising the NHS and social care workforce.¹⁷⁵ Reports from the first two years demonstrate progress in a number of areas, whilst acknowledging that further work is needed in some trusts, sectors and wider parts of the NHS. We are conscious of the recent pledge for the NHS to ensure ethnic minority representation at very senior management levels will match the levels reached across the rest of the NHS workforce within 10 years.¹⁷⁶ Whilst we endorse the aims of these existing NHS-wide programmes and encourage further progress, there are particular disparities in relation to mental health services which deserve a greater focus.

There are not enough staff from certain ethnic minority backgrounds, in particular black African and Caribbean communities, working in mental health services. Service users reported that they often felt that they were not understood by those meant to deliver therapy and that this was then used as a reason to exclude them. Efforts to change this would result in staff with different approaches, including different cultural understanding, which would increase the ability to offer meaningful support to people from ethnic minority backgrounds. This would increase the likelihood of different cultural approaches to care and treatment

“All you need to do is look at, all the, psychologist (...) they’re usually White, they’re usually female. None of them studied transcultural therapy, so they don’t know what ya know [about the impact of racism and discrimination] and what they then say is that “the person’s not therapeutically minded” (...) so they wouldn’t be offered an alternative [to psychotropic medication]”¹⁷⁷ – AMHP

¹⁷⁴ Service user, comment in Mental Health Act survey

¹⁷⁵ <https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/>

¹⁷⁶ <https://www.gov.uk/government/news/nhs-pledges-action-to-eliminate-ethnicity-pay-gap>

¹⁷⁷ AMHP comment, focus group

We acknowledge ongoing work led by the Royal College of Psychiatrists to address issues within the psychiatry profession,¹⁷⁸ and would encourage other professional bodies to promote greater representation, particularly in psychology and occupational therapy, where rates of ethnic diversity are very low¹⁷⁹. Professional bodies overseeing registration should take steps to address the lack of ethnic minority representation in these professions. In line with our recommendations below, we also believe that people of black African and Caribbean heritage should be supported to reach their potential to rise to senior levels of across the professions, including psychiatry and psychiatric research, psychiatric nursing and management. We call upon the Academy of Medical Royal Colleges to address this across the entire profession of medicine – because this is a problem across medicine, and not just mental health.

In addition, whilst we recognise ongoing efforts to increase cultural competence throughout the NHS workforce as a whole, it is clear that the current focus on training is insufficient to tackle these issues.¹⁸⁰ Despite the fact that any underlying institutional racism is mainly unconscious, not deliberate, addressing this prejudice is clearly necessary to help reduce the significant overrepresentation of ethnic minority individuals in detention under the Mental Health Act. As a minimum, the government should ensure that regulations and standards governing key decision-making professions involved in the MHA, such as AMHPs and psychiatrists, are relevant and fit for purpose.

We would like to see further work involving clinicians, service users and carers to determine what behavioural ‘nudges’ might impact on biased decision-making – and how these could be piloted effectively. Importantly, attention must also be paid to the role of unconscious racial bias between different minority ethnic groups which may influence decision-making around patient care, as well as workforce decisions and development.

“[I] Feel like our experience has been professionals come with stereotypes, [which are] usually negative if [a] black person. [It] Seems [professionals] have to make a special effort to treat us like human beings”¹⁸¹ – Service user

¹⁷⁸ <https://www.rcpsych.ac.uk/mediacentre/pressreleases2018/statementonracism.aspx>

¹⁷⁹ Skills for Care 2018 and NHS Digital 2015

¹⁸⁰ <https://www.equalityhumanrights.com/en/publication-download/unconscious-bias-training-assessment-evidence-effectiveness>

¹⁸¹ Service user, comment at Focus Group, Independent Review of the Mental Health Act

Data and research priorities

The limitations of current national data reporting across mental health makes it very difficult to improve the experiences of minority ethnic groups, with the use of high level categories often blurring not insignificant distinctions between separate communities. The striking lack of ethnicity data across public bodies severely limits our ability to understand the wider experiences of many minority communities, particularly in cases where individuals identify with two or more 'ethnic categories'. We are recommending that data and research on ethnicity and use of the MHA is improved, to inform future policy and practice. Organisations covered by the MHA should be required to record and review ethnicity at every decision-making stage of the process, using an agreed set of definitions. This should include criminal justice system organisations and Tribunals, and should build upon the recent Mental Health Units (Use of Force) Act which requires mental health units to publish data on how and when force is used (further detail of which can be found in 'Coercion and restrictive practices within inpatient settings'). Efforts to harmonise definitions of ethnicity across public services could be informed in line with existing work by the Race Disparity Unit and the Office of National Statistics.

Research concerning MHA detentions consistently shows higher levels of detention in black African and Caribbean people. The explanations given for these detentions are often based on stereotyped assumptions and not backed up by evidence, and may be driven by structures which are inherently biased against black African and Caribbean people¹⁸². We believe that there is a need for a fundamental reset of research into black mental health. It is vital that future research is of high quality but, above all, that any conclusions reached are reviewed in light of this forthcoming new evidence. Direct input of researchers from black African and Caribbean backgrounds should be sought to improve the quality and specificity of the research questions considered. We urge research bodies to support the pipeline of proficient academics from black African and Caribbean backgrounds, as well as to endorse and disseminate higher quality research into interventions to improve mental health outcomes for these communities.

We welcome proposals within the recent Green Paper on children and young people's mental health provision which committed to greater collaboration at local level to tackle early signs of mental health issues.¹⁸³ However, we feel that further attention is needed to assess the value and nature of suitable interventions for black African and Caribbean children and young people, particularly young boys at risk of school exclusion. It is

¹⁸² Barnett et al. *Lancet Psychiatry*. (Forthcoming publication)

¹⁸³ <https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper>

important to build a greater understanding of the background to poor mental health in this particular group, including individual and societal factors which contribute to worsened outcomes. We endorse work currently underway through the Review of school exclusions, particularly to identify approaches to improve outcomes for groups disproportionately likely to be excluded.¹⁸⁴ In addition, we recommend the piloting and evaluation of interventions to address issues of childhood adversity and trauma. In doing so, this should improve access to help, reduce the likelihood of development of more severe mental health conditions, and avert later use of crisis care and detention.

“people migrate from other countries, coming from, significantly war torn areas where they are, they’ve seen horrors that we couldn’t even dream about (...) or have nightmares about, and these people are in the system. English not their first language (...) they’re rejected from one place to another. They come here seeking asylum or seeking, care and support, and they, experience racism (...) [It’s] multi layered (...) People are forced into zero hour contract jobs. People are forced into substandard housing (...) so there’s so all these social factors are building layers of mental ill health – migration, racism (...), social disadvantage all those layers (...) and that if those issues aren’t being addressed, then how are you expecting, mental health, admission rates to go, down, how, how?”¹⁸⁵ – AMHP

The call for further research on interventions for black African and Caribbean people should be mirrored in relation to other minority ethnicities, with a focus on current gaps in awareness and understanding (such as, for example, the comparatively positive experiences of Chinese individuals). Only through greater appreciation of the multiplicity of experiences can services truly respond to individual cultural needs. As with all our recommendations, future work should be co-produced as standard, working alongside communities to understand people’s experiences and to highlight the narratives and views of those with lived experience.

¹⁸⁴ <https://www.gov.uk/government/publications/school-exclusions-review-terms-of-reference>

¹⁸⁵ AMHP comment, focus group

What we are recommending

- **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).**
- **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.**
- **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.**
- **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.**
- **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.**
- **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.**
- **Behavioural interventions to combat implicit bias in decision-making should be piloted and evaluated.**
- **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.**
- **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**

- **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

The problems caused by rising numbers of children and young people that are diagnosed as suffering from mental ill-health are often laid bare in the media. And the heart-breaking stories that are all too often reported are rarely exaggerated. Children and young people present particular issues not only because of their age and vulnerability but also in relation to their ability to make their own decisions. This means that they have particular needs that are different to those of older people.

Our recommendations draw upon the wide range of experience and evidence gathered during the Review. While many of the recommendations made in other areas of this report also apply to children and young people (for example our recommendations on advocacy and nominated persons), this section concentrates on the particular needs of children and young people. We have made recommendations in two main areas: the legal basis for admission and treatment; and proper safeguards and procedures. Above all, we want to establish a proper balance between the rights of young people and those who are legally responsible for them, usually their parents. Those with parental responsibility not only have their own rights, but are vitally important to the future care and welfare of a child or young person.

The legal basis for admission and treatment

At the moment, the legal position is complicated in relation to the admission and treatment of children and young people in two key respects:

1. A lack of clarity about which legal test to apply as to whether the child or young person is able, themselves, to consent to their admission or treatment;
2. A lack of clarity about the ability of those with parental responsibility to consent on behalf of a child or young person to either their admission or treatment.

We address each of these below.

The ability of the child or young person to make their own decisions

As a starting point, we think that the law should be clearer about whether the child or young person has the ability to make relevant decisions for themselves. The law usually divides those under 18 into two categories; for children under 16, it talks about decision-making ability in terms of ‘competence’ (and, usually, about ‘Gillick’ competence)¹⁸⁶; for young people between 16 and 18, it talks about decision-making ability in terms of ‘mental capacity.’

For children under 16, there is no consistent approach to establishing competence. We think that there should be a single approach to establishing whether children are able to make their own decisions in this context. We are basing our proposal on the current system for those over 16 on the one set out in the MCA. We think that the functional test set out in section 3 of the MCA should be used to determine whether a child can either consent to admission or make decisions about medical treatment for mental disorder. There would be no presumption that the person has the ability to make their own decisions, and the ‘diagnostic’ test set out in section 2 of the MCA would not apply¹⁸⁷. Instead, it would be for the child to show that they have the ability (competence) to make the relevant decision. Recent case-law shows that the law is already moving in this direction,¹⁸⁸ and we think that this should be confirmed in statute. We recognise that changing the test would have implications going beyond the MHA to decision-making by under 16s more generally and we are limiting ourselves to the position in relation to whether the child in question has the ability (is competent) to agree to either admission or treatment for mental disorder.

¹⁸⁶ After the decision of the House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] UKHL 7.

¹⁸⁷ In other words, the requirement that the person’s inability to make the decision is because of an impairment or disturbance in the functioning of their mind or brain.

¹⁸⁸ *Re S (Child as Parent: Adoption: Consent)* [2017] EWHC 2729 (Fam); the MHA Code of Practice (at paragraph 19.36) also suggested a similar approach to competence.

For a 16 or 17 year old, we think the only test that should be applied when deciding whether the young person can consent to admission or treatment, should be that set down in the MCA. We think that it is unhelpful and confusing to have other tests that may need to be considered (such as whether the young person has mental capacity but nonetheless lacks competence¹⁸⁹). It may be that the forthcoming decision of the Supreme Court in *Re D* resolves these matters; if not, we think the MHA should make this clear.

Admission and treatment on the basis of parental consent: 16 and 17 year olds

The second area of legal complexity that arises is the extent to which a person with parental responsibility¹⁹⁰ can agree on behalf of a child or young person either to their admission to hospital or to treatment. The complexities have been increased by the fact that most admissions to psychiatric hospital mean that the child is 'confined' (or 'kept within hospital'). If there is no consent to that confinement, there will be a deprivation of liberty, which will require authorisation either under the MHA or (in future) under the LPS in relation to 16/17 year olds. The Supreme Court is considering the extent to which a parent should be able to consent on behalf of their 16/17 year old child to either confinement or treatment in the *Re D* case.¹⁹¹ Government will need to consider the conclusions of the Supreme Court before implementing our recommendations.

If a young person has capacity to consent to admission and does not agree to admission, then we think that the current position in section 131 MHA should be maintained: i.e. that they cannot be admitted as an informal patient on the basis of the consent of their parent / a person with parental responsibility. The clarification of the test for decision-making in the context set out above will also make clear that a parent could not consent to the young person's admission on the basis that the young person has capacity but is said to lack Gillick competence.¹⁹²

¹⁸⁹ As was suggested by the Court of Appeal in *Re D* [2017] EWCA Civ 1695; the Codes of Practice to the MHA and the MCA also suggest other circumstances where a young person could be unable to make a decision for a reason falling outside the MCA.

¹⁹⁰ We are here talking not about local authorities who may have parental responsibility through a court order; it appears relatively clear, and we would agree, that they should not enjoy the same rights here as birth parents.

¹⁹¹ The case arises in the context of a young person in a residential and educational facility, but the issues of principle apply equally in this context.

¹⁹² This was not a position contemplated by the drafters of s.131 MHA, but is now a possibility opened up by the decision of the Court of Appeal in *Re D*.

If the young person lacks capacity to consent to admission, and that admission means that they will be confined, then we think that they should be treated as if they were an adult, and that the law should recognise that they are deprived of their liberty. This means that a framework will need to be put in place to authorise that deprivation of liberty. In line with the approach that we have set out in the 'Deprivation of Liberty: MCA or MHA?' section, if they are objecting to either their admission or treatment, then the MHA would have to be used; if they are not objecting, then they would be admitted to hospital and made the subject of an authorisation under the Liberty Protection Safeguards. This does not exclude parents. We understand that the Liberty Protection Safeguards will require consultation with those with parental responsibility in the case of 16/17 year olds, as they fall within the definition of "anyone engaged in caring for the cared-for person or interested in the cared-for person's welfare."¹⁹³ We are in total agreement with this.

We recognise that this means that parents will not be able to ask for their 16 or 17 year olds to be admitted as informal patients, where they will be confined.¹⁹⁴ However, we understand that most psychiatrists think that they shouldn't rely only on parental consent. This reflects the fact that restrictions in place in psychiatric units need to be recognised for what they are: a (necessary) deprivation of the young person's liberty, to which it would be wrong to expect the parent to be able to agree on their child's behalf. That we are putting the position beyond doubt does not mean that we are cutting out the place of parents in the decision-making process. They will still be involved, either through a parent being the Interim Nominated Person,¹⁹⁵ or through the consultation process required in the proposed Liberty Protection Safeguards.

We want to be absolutely clear that our recommendations should not result in more young people being admitted to hospital against their will. But they will ensure that those that do have appropriate safeguards. Whilst we know that some parents will have concerns about this; we have also heard from some who will be relieved to have the burden of decisions taken from their shoulders; as previously mentioned this will not exclude parents from involvement with their child's care which will continue either through their role as INP or through the other safeguards in place.

¹⁹³ Paragraph 20(2)(c) of Schedule AA1 to the Bill. It may be better if parents are specifically listed. It would be possible - and potentially better - to make express reference to those with parental responsibility on the fact of the Act.

¹⁹⁴ If the young person's admission is to a hospital where they are not to be confined (i.e. they will not be under continuous supervision and control, and are free to leave), then a parent may still be able to consent, but, as set out above, we think that the reality of psychiatric hospitals is such that such this is very unlikely.

¹⁹⁵ Exceptionally, a young person with capacity may have nominated someone other than one of their parents to be their Nominated Person, but their parents will still have rights to be provided with information.

In light of these recommendations, the separate question of whether parents should be able to consent to medical treatment on behalf of 16/17 year olds in this context may become less relevant. However, because of the nature of medical treatment in psychiatric hospital, we think that 16/17 year olds should in this context, again, be treated as adults. This means that, if they are detained under the MHA, then the treatment safeguards in the MHA will apply; if they are subject to the LPS, then treatment decisions will be made on the basis of their best interests, applying the MCA. In both cases, their parents should be consulted through the relevant mechanisms under the MHA/MCA, but they should not be asked to make decisions on behalf of the young person. If the 16/17 year old has capacity to make decisions, we think that the MHA should put beyond doubt that a parent cannot consent on their behalf if they refuse treatment.¹⁹⁶

Admission and treatment on the basis of parental consent: children under 16

In relation to children, we have found the issue of the role of parental responsibility much more difficult. As we say above, we think that we need to strike the right balance between the rights of those under 16 to make their own decisions where they are competent to do so¹⁹⁷ and the importance of parental involvement. However, there were a range of strongly contrasting views within the Review on where the balance should be struck, in particular in relation to:

1. Whether parents should be able to consent to either the admission or treatment of a competent child who is objecting to either the admission or the treatment;
2. Whether parents should be able to consent to either the admission or treatment of a child who lacks competence, but is objecting to either the admission or the treatment.

In the circumstances, our recommendation is that government consult widely on this issue. The MHA Code of Practice is clear that it is “inadvisable” to rely on parental consent to admit or treat a competent child under 16 who is objecting to either the admission or treatment (para 19.39). We don’t want to undermine this but we think a consultation will enable the government to see how this is currently working in practice, and understand the complexities of and range of views on the issue, before considering whether legislation or

¹⁹⁶ If they have capacity, then the consent of the parent is unnecessary under s.1 Family Law Reform Act 1969. Old age-law, in particular *Re W (Medical Treatment)* [1993] Fam 64, suggests that a parent could still override the refusal of any child/young person under 18 even where a 16/17 year old has capacity to and is refusing.

¹⁹⁷ Taking into account, in particular, the United Nations Convention on the Rights of the Child.

further guidance is necessary. We also think a consultation will help the government decide whether there needs to be further clarification in relation to the position for under 16s who lack competence who are objecting to their admission or treatment.

Young people: the importance of parental Involvement

We think that it is important to recognise 16 and 17 year olds as autonomous individuals, even if they make unwise decisions (including for instance in relation to the choice of their Nominated Person, admission or to specific treatment decisions). However, we recognise that parents play a vital role at this age, and we want to ensure that they are still able to be fully involved in the young person's care. We are recommending that the importance of parents and carers' involvement is strengthened in the Code of Practice, including the provisions relating to information given to parents and carers where they are not the Nominated Person. Guidance should also be clear about the rights of parents and carers to participate in the Statutory Care Plan if the person is 16 or 17.

Rights for Children and Young People and their families and carers

We know that families and carers usually only want what is best for their child. Sometimes, conflicts can arise with the clinical team about how the interests of their child are met. We are particularly concerned about instances where contact between children and their parents is severely restricted and where the conditions in which the child or young person is clear are kept are at odds with the wishes of the parents. For these reasons we are recommending that parents and carers should have: a right to advocacy alongside that of the child or young person; a right to be involved in care and treatment planning meetings; and that support is given to ensure that families can afford to travel to see their loved ones when they are hospitalised away from their home catchment area (Out of Area).

In the chapter on Advocacy we are recommending that the right to an independent mental health advocate (an IMHA) is extended to every inpatient and their parent or carer. This will include informal patients. If the result of the government consultation we have recommended above in relation to under 16s is that parents should be able to consent (in all or some circumstances) to their children's admission even into circumstances of confinement, these children would also have access to an advocate.

We are further recommending that children and young people should have access to an IMHA who is trained to work with children, young people and their families. We are also recommending, that every informal patient under the age of 18 should have a personalised care plan based on guidance and standards such as those provided by the Quality Network for Inpatient CAMHs (QNIC) and which records the views and wishes of the child or young person on each issue.

It is particularly important that children and young people should not drift in the system; that is vital both for them and their families, and is especially true where they are placed far away from home. Proper review and planning for discharge is fundamental to make sure this does not happen. There should, as currently exists in best practice, be a system of regular reviews. We think the government should consider whether these reviews should be on a statutory footing where the child or young person is an informal patient (which means they will not have a Care and Treatment Plan) and does not already have any statutory care plan. We are recommending that these reviews include consideration, alongside the care and treatment that the child or young person is receiving, of whether:

- the child or young person should continue to be treated in hospital
- (if the child or young person is there informally), whether it is appropriate that they continue to be there informally
- appropriate discharge planning is in place
- the placement and physical conditions in which the child or young person is accommodated is right for his or her needs
- proper transition planning is in place in based on existing guidance, such as the QNIC and NICE guidelines

In line with NHSE service specification for Tier 4 CAMHs¹⁹⁸ the first review should take place within five days of emergency admission (we recommend that this is three days if the child or young person is placed in an adult facility) and thereafter at four/six weekly intervals at a minimum.

¹⁹⁸ <https://www.england.nhs.uk/wp-content/uploads/2018/02/tier-4-camhs-general-adolescent-service-specification-v3.pdf>

These reviews should take a child-centred approach that routinely involves parents and the NP where this is different, unless this would be harmful for the child or young person (e.g. because there is an established safeguarding risk). This should include the sharing of information so that parents and carers are equipped to help with future care.

We are aware that, with some limited exceptions, SOADs are not currently available for informal patients. We think move towards having a right to a second opinion at the first review that is independent, but may not be a SOAD. We also think that each review should also include an independent chair similar to a local authority 'Looked After Child' review. That person may not need to be medically qualified but must have sufficient authority to chair meetings and a sufficient understanding of the needs of that child or young person. We recognise that implementation of this is not possible at the moment, because of a lack of resources but we think units should consider how they can move towards the allocation of independent chairs by training staff for chairing roles and appointing chairs from staff not directly involved in the care of the child or young person as far as is possible.

Placements in Adult Wards or Out of Area

Sometimes a child or young person may be placed in adult wards and away from their family, and/or in an adult unit or ward. There may be good reason for this either because there is an emergency (any bed is better than none); because specialist treatment is not available in the area; or there is some other reason e.g. because a young mother wishes to be placed with her child. Where this happens, the local authority where the child or young person comes from should be informed.

As we set out in our section on Inpatient Physical Environments it is essential that people are appropriately accommodated. Children and young people may be particularly vulnerable and we want to strengthen the safeguards for those who are placed in adult wards or out of area.

For children and young people placed in adult wards we think that the CQC should be informed within 24 hours, (as opposed to the current 48 hour requirement) and that they record both the reasons for placement and the proposed length of it. This will enable the CQC to, for instance, consider a regulatory response, share information with NHSE, and report national figures. The first review of these placements should take place within 3 days of admission and must include consideration of moving the child or young person to more suitable accommodation.

We also think that the requirement to inform the CQC should be extended to children and young people who are accommodated out of area.

We also recognise the impact of travelling long distances on the ability of the family to support the child or young person post-discharge. We know that there are processes that help parents and families to be supported to stay in contact with children and young people placed out of area and that the Code of Practice provides guidance on supporting parents to maintain communication. However we recommend that Government consider formalising this through the introduction of a new right to support (financial and/or practical) for parent(s), carer(s) and family member(s) to visit the child or young person who is placed out of area.

Safeguarding and transition back to the community

It is crucial that the local authority in which the child or young person is based is able to keep track of the child or young person. This is particularly important for supporting transition from hospital back to community care and for care after discharge. There needs to be engagement of all those involved, whether professionally or not, in the care of the child or young person. The evidence has repeatedly emphasised the need for coherent care planning that includes all the organisations that will be involved in the delivery of post discharge care.

We think that a child or young person who has been admitted to hospital for their mental health will already fall within S.17 of the Children Act 1989 and so be regarded as a 'child in need' but we are recommending that the section is amended to make this clear. We are also recommending that the local authority in which the child or young person ordinarily lives, should be notified if any admission (either informal or compulsory detention) lasts more than 28 days¹⁹⁹ The effect of this would be to allow parents to ask for services from their local authority.

In line with the proposal set out in Care Planning and After-Care, there should be an increased focus on discharge planning. For both informal and detained children and young people, any statutory care plan, such as an Education, Health and Care Plan, should be revised at the point of discharge to reflect recent experiences and any changes in care needs.

¹⁹⁹ If the child or young person is being detained and is a 'looked after child', para 14.97 of the Code of Practice which requires AMHPs to inform local authorities of detentions will continue to apply

This is particularly the case as many of the services children and young people will require following discharge should be available under Part III of the Children Act 1989 or as part of an Education and Health Care Plan under the Children and Families Act 2014, and it is important that they have a single, integrated and personalised plan which outlines the care and support they need.

Data on age

Some legislative duties which apply to children and young people also apply to those over 18 and up to 25. We accept that different ages may apply in relation to different provisions and to different decisions. This means that it is particularly important where data is recorded it should be split into age groups.

What we are recommending

- **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**
- **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**
- **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**
- **Government should consult on the ability of parents to consent to admission and treatment for those under 16.**
- **Every inpatient child or young person should have access to an IMHA who is trained to work with young people and their families.**
- **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**
- **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**

- **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.**
- **Government should consider making it a requirement that the parents and families of young people placed out of area are supported to maintain contact.**
- **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**
- **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.**
- **Where data is recorded it should be split into age groups.**

PEOPLE WITH LEARNING DISABILITIES, AUTISM OR BOTH

The Review has specific concerns about the way the MHA works for people with learning disabilities, autism or both which require attention.

It is clear that the current implementation of the MHA cannot remain unchanged. The wider system needs to be able to facilitate change so that the Act can be used as intended, as a response to a vulnerable person in crisis that will improve their mental health and nothing more than that. The Review recommendations cannot achieve this on their own. There is an overwhelming need for a sustained programme of investment to ensure, that as far as possible, people are cared for in the community; admission into hospital is only used as a last resort at a point of crisis; and that services can facilitate a timely discharge. This is also necessary to prevent the vicious circle of readmission because services are unable to provide the continuous support that is required. We are encouraged by the discussions informing the forthcoming NHS Long Term Plan and want our recommendations to compliment and support this work.

We are confident that we are making recommendations that will bring about fundamental change. Our recommendations will make it more difficult to admit someone to hospital when alternative options are available, and for patients to be subject to long admissions without a therapeutic benefit. Our recommendations should also help prevent people from being unnecessarily pushed into the Criminal Justice System.

We have heard throughout the Review that the MHA is being used inappropriately for people with a learning disability, autism or both, to deal with a crisis that has arisen because of a lack of good community care or placements. Mental health professionals often misunderstand that for some people, exposure to certain environments or experiences can cause stress leading to difficult or challenging behaviour, which could be addressed with alternatives to detention rather than a long inpatient stay in hospital. If the learning disability or autism spectrum disorder is properly recognised and managed, the right kind of intervention can deescalate the crisis so that detention is not required.

We have also heard significant testimony of, and been persuaded by, concerns from service users, families and stakeholders about the care people receive when they have been detained. It is particularly intimidating for a person with autism, learning disability or both to be removed from a place they are familiar with or from people they know, even if at the time there seemed little alternative. We also accept that being placed in an environment that lacks 'reasonable adjustments' is far from ideal. Some families tell us that the system is not designed around the person's needs. Instead of improving their mental health, the environment (including relationships with staff) has made them worse, not better. We accept this. Likewise, there are cases where there has been a disproportionate use of restraint and medication to "treat" someone without an effective route for them to challenge these decisions. This can be the cause of continued detention for an extensive period. We also accept that it can be problematic to secure a timely discharge because of an inadequate number of local care placements available and/or problems securing appropriate finance from providers to develop a care plan, although we also acknowledge the significant and sadly rising pressures that are faced by local authorities. For some people, this means there is no realistic prospect of discharge, even though, with the right support, they are well enough to leave. This has led to families losing confidence in a system that is supposed to help their loved one.

We have also heard concerns that the professionals delivering care do not understand the specific needs of a person with a learning disability, autism or both. Families are often best placed to understand these needs, but when they try to help some report that they can be made to feel like a nuisance and their experiences are not listened to or acted upon.

There are wider concerns about workforce and the level of expertise about learning disabilities, autism or both amongst professionals working in MHA services. We agree there is a shortage of expertise which can make a person's experience of detention more difficult. We would like this to improve and it is an ambition that we want the government to work towards. However, we recognise that this needs to be considered as part of the wider work to improve learning disability and autism services.

Despite the problems above, there are examples of the MHA being implemented that represent the overarching principles of delivering care with a therapeutic benefit, fostering a culture that supports the individual and taking a collaborative approach with professionals and families so that the person will become well enough to be cared for in the community. In our view, this illustrates that the MHA can and does work for people with a learning disability, autism or both and that we should prioritise trying to make this experience of the majority, if not all.

As well seeking to improving how the MHA works for people with a learning disability, autism or both, we have considered whether or not these conditions should be within the scope of the MHA. The current definition of mental disorder within the MHA includes learning disabilities and the full range of autism spectrum conditions. However, a person with a learning disability will only be detained for treatment under the Act if their behaviour amounts to “abnormally aggressive or seriously irresponsible conduct.” Controversially, there is no similar criterion for people with autism. Many families that we heard from feel strongly that learning disabilities and autism should not be defined as a mental disorder. In addition, some feel that including these conditions within the definition contradicts the view that they are lifelong disabilities rather than a treatable health condition. There are powerful arguments in favour of this. However, others, including patients and carers wanted to maintain the current position in the MHA which they feel is the only framework that will keep people safe at a time when they are most vulnerable, or where detention has been the only relief available for those experiencing a crisis because there is no alternative option available to support them. If this framework was removed there is a risk that no care will provided at all. This could lead people to be misdiagnosed with other mental disorders in order to obtain care, or, potentially worse, people could be forced into the Criminal Justice System which is not able, or indeed intended, to cater for their needs. In our view, the issues arising from taking learning disabilities and autism spectrum conditions out of the Act are significant and could cause further harm.

We recognise that these are difficult and finely balanced issues. We concluded that our Review was not established to consider the best approach in law to be taken in relation to the care and support of people with learning disabilities and autism. That would be a much wider task.²⁰⁰ We believe that, with more robust safeguards to ensure the MHA is used appropriately, the MHA has a place in our society for those with a learning disability, autism or both, and we should not change the way that either is treated. These arguments

²⁰⁰ The Independent Review of Learning Disability and Autism in the Mental Health Act in Scotland: <https://www.irmha.scot/> is underway at the moment, and the Government may well wish to take account of its conclusions in drawing up its legislative response to our recommendations.

will continue to evolve and develop over time and Government should keep this issue under review.

Our main objective is to improve how the MHA is implemented, not just for people with learning disabilities and autism but for all patients, and to develop both legislative and non-legislative frameworks that provide effective safeguards for people and their families. So our preference has been to make recommendations that will benefit every person who is detained under the MHA, but might have a particularly significant impact on people with a learning disability, autism or both.

Review Proposals

We want to set out here how some of the proposals we are making elsewhere in this report should be particularly helpful to patients with learning disabilities, autism or both.

We are recommending changes to the detention criteria to establish a culture which is less risk adverse because it too easy for the behaviour of a person with a learning disability, autism or both to meet the current threshold of risk. When detention is being considered, professionals will need to focus on more than just a person's presenting behaviour that is perceived to be challenging. There will need to be a 'substantial risk' of 'significant harm'. We are asking that this harm is specified on the application form, and will need to be evidenced, encouraging the person making the application to think carefully about the likelihood and severity of the harm they perceive. New treatment criteria will prevent 'warehousing' of patients without treatment, something that we have heard is more likely to happen for people with learning disabilities, autism or both. We are requiring that treatment must benefit the patient, and that it cannot be delivered without detention. This will mean that alternatives interventions in the community must be considered first. Our new Care and Treatment Plan will require clinicians to set out exactly what treatment will be provided, what improvement in their health is expected as a result, why someone needs to be detained to receive it, how this is least restrictive option, and commencing discharge planning at an early stage.

Elsewhere in this report, we are proposing changes that will require clinicians to follow NICE guidelines more closely (which include specific guidelines in relation to learning disability and autism) and to pay closer attention to the patient's choices as regards treatment. For those who lack capacity to make decisions about their medical treatment, the 'best interests' approach that we are recommending will require proper consideration of their wishes and preferences. We are also proposing that a person's wishes and preferences will have much more impact and be harder to ignore than before.

Challenging treatment decisions

We are proposing changes that will give people more control over treatment decisions. Access to a SOAD will be easier and earlier than before, providing better access to an important and effective safeguard. If a patient is still not happy with the treatment, following a SOAD decision, we are proposing giving them a new right to appeal treatment decisions to the Tribunal. If the patient does not have capacity to make an appeal, their nominated person or an advocate can make it on their behalf. These changes will mean that clinicians will face more pressure to justify that first they really are delivering treatment, and second, that this treatment either is, or provides a realistic chance of, benefitting the individual.

Nearest Relative reform

We are replacing the nearest relative provision with a Nominated Person to enable people to choose who they want to be their point of contact if they are detained. The powers of a nominated person will mostly be the same, but we are making recommendations to so that the role can be a more effective safeguard. This includes upgrading the right for the nominated person to be notified of renewing detention, the right to be consulted about a person's care plan and the ability to appeal treatment decisions if the service user is unable to do this themselves. We have also changed the processes for replacing the nominated person.

Dividing line between the Mental Capacity Act (MCA) and the Mental Health Act (MHA)

We are clarifying the dividing line between the MHA and MCA to address the confusion about which legal framework should apply at a point of crisis. This will make it clear that the MHA should only be used if a person is objecting to their detention. If a person lacks capacity and is not objecting, a common scenario for people with a learning disability, autism or both, they should receive care and treatment under the MCA. We expect this to reduce the number of MHA detentions as well as long and arbitrary stays in hospital.

To facilitate this, we are also recommending that the new Liberty Protection Safeguards (LPS) should apply to people who are at risk of harm to themselves and/or others.

Information and Support

It is crucial not least to comply with the Equality Act 2010, that people who are detained are provided with information about what is happening to them in an accessible form that works for them and their needs. We are aware that this provision of information is very patchy, and needs to be improved. People with learning disabilities and /or autism will benefit from our recommendations to strengthen legislation to ensure people are made aware of their rights in a way that they will understand and supports them to contribute to decisions as far as possible. This will be supported by our recommendation that IMHAs are provided to all inpatients, unless they “opt-out”.

Specific Recommendations

We recognise that for people with a learning disability, autism or both there needs to be some specific changes.

A new Statutory Duty for Health and Social Care Commissioners

We are recommending that health and social care commissioners are given a new statutory duty to collaborate to ensure a sufficient supply of community-based support and treatment for people with a learning disability or autism to avoid admission into hospital and discharge people back into the community. Commissioners will need to take a joined-up approach to provide the right support in the local community, which should take account of NHS England’s plan “Building the right support”²⁰¹.

Amendments to the Code of Practice

There are several points that need to be clarified in the MHA Code of Practice. These changes as set out below will have the most impact if the Code’s statutory authority is extended to NHS Commissioners in the same way it applies to Local Authorities and service providers in relation to their AMHP roles. We can see no reason why this should not be implemented.

²⁰¹ NHSEngand, ADASS, LGA , Pub Oct 2015
<https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf>

It should be clear in statutory guidance that the MHA should be used with caution for people with learning disabilities, autism or both. If a person is admitted to hospital, the Code of Practice should emphasise the importance of making reasonable adjustments to ensure a person is not unnecessarily distressed by their environment. This could be strengthened by the inclusion of illustrative scenarios and input from experts with experience.

The Code of Practice should also protect against overuse of medication, e.g. for managing outbursts of aggressive behaviour. We have seen NHS projects such as STOMP addressing this issue but they need to go further. The underpinning principles applied in STOMP should be reflected in the Code of Practice as an exemplar of what good care should look like.

The Code of Practice should remind clinicians of their responsibility to arrange and/or provide care for physical health issues that arise during a person's stay in hospital. The Code should require clinicians to acknowledge that someone's behaviour may be a result of a problem unconnected to their mental disorder and therefore mental health treatment may not be effective.

Care and Treatment Reviews

Care and Treatment Reviews (CTRs) are part of NHS England's commitment to transform services for people with learning disabilities, autism or both. CTRs are held to discuss the care needed by people with learning disabilities, autism or both who are either at risk of being, or who have already been, detained in an inpatient psychiatric unit, and to overcome barriers to progress. The CTR meeting is chaired by the commissioner and includes the service user, their family, their multi-disciplinary team, two independent experts (one of these should be family carer or a person with a learning disability), and a clinical expert.

We have been told they can be an effective way to reduce hospital admissions and for professionals to take a holistic approach to their care in the community. We are recommending that CTRs are placed in statute, to strengthen their authority. A statutory footing with require professionals to recognise CTRs are in place and explain why any recommendations made in the CTR are not being implemented. If a service user or their nominated person want to appeal a treatment decision, the Tribunal will be able to place greater weight on the CTR when reviewing the evidence, alongside the CTP when considering whether the detention criteria are met.

Improving Data Collection

There is a clear gap in the accessibility and quality of the data collected about people with learning disabilities, autism or both. Without this, it is difficult to assess for certain the effects of detention on people with learning disability or autism, and how well services are being delivered.

We welcome the inclusion of learning disabilities and autism into the Mental Health Services Dataset but this doesn't go far enough. We would like to see more detail that accurately records why a person has been detained, the circumstances of surrounding the detention (and in line with our recommendation, to carry out a capacity assessment, what assessment was made of capacity), information about care and treatment, discharge planning as well as a person's characteristics. This additional information should help to hold services to account when they are delivering care and driving change.

Our Recommendations

These recommendations should be read in conjunction with the wider recommendations for all patients that will be of particular benefit to people with learning disabilities, autism or both.

- **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.**
- **Amend the MHA Code of Practice to clarify best practice when the MHA is used for people with autism, learning disability or both.**
- **Care and Treatment Reviews should be given statutory force in the MHA.**
- **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 AND THE MHA

Police officers work tirelessly to protect the public and to keep them safe, and they make a major contribution to the responses that people receive when in mental health crisis. We heard numerous examples of police treating those with mental health problems with kindness and compassion. We are also pleased that data for 2017/18 showed that police cells were used as a place of safety 400 times in England, a reduction of 95% from 2011/12. Ideally, we want to get this down to zero. But we recognise that there were over 25,700 uses of the police power under section 136 altogether in 2017/18²⁰², meaning that police officers took people to health based places of safety in over 23,330 cases, making every effort to avoid the use of police cells, and to ensure that people get attention in a therapeutic environment.

Despite this progress, it has remained the case for some years that after someone has been detained by police under section 136, there then follows a more than even chance that they will be taken to hospital in a police vehicle, often in a van used for transporting criminal suspects. This is despite the clear guidance in the Code of Practice that ambulance vehicles are the preferred method of conveyance and should be made available in a timely manner when it is needed. We have heard from many service users how demeaning and distressing this can be.

We have also heard how some people are being detained for too long in a police cell because a bed cannot be found. A survey of police forces estimated that up to 4,500 people a year continue to be kept back in cells well after the point at which they have been assessed as requiring detention under the Mental Health Act, despite the Act specifying in section 140 that arrangements must be in place to receive patients in cases of special urgency.

Finally, but most importantly, the Review was asked specifically to look at the experience of people from ethnic minority backgrounds who are detained under the Act. David Lammy MP, Dame Elish Angiolini and Lord Victor Adebowale have all led reviews that have reported clearly on matters concerning people from Black, Asian and Minority Ethnic communities and their experiences with the police and the wider criminal justice system. The 2013 Independent Commission on Mental Health and Policing²⁰³ chaired by Lord Adebowale found that supporting people experiencing mental distress or ill health is a core

²⁰² <https://www.gov.uk/government/statistics/police-powers-and-procedures-england-and-wales-year-ending-31-march-2018>

²⁰³ http://www.turning-point.co.uk/media/621030/independent_commission_on_mental_health_and_policing_main_report.pdf

part of day-to-day police business. The report made recommendations to the Metropolitan Police Service in a number of areas, including leadership, culture, the use of force and approaches to race and ethnicity. These are practical recommendations that we endorse.

In common with these reviews, we are of course acutely aware of those tragic cases in the recent past in which young Black men in mental health crisis have died after inappropriate police responses. We endorse the Memorandum of Understanding²⁰⁴ published by the Mental Health and Restraint Expert Reference Group convened by the College of Policing under the chairmanship of Lord Carlile of Berriew QC CBE. We eagerly await the completion of Phase 2 of the Group's work 'exploring how the use of restraint by police is reduced in incidents involving mental health conditions in non-mental health settings and public places', which is likely to be of major interest to many of the stakeholders interested in our Review.

Case study: Northumbria Street Triage

A collaboration between Northumbria Police and Northumberland, Tyne and Wear NHS Foundation Trust (NTW), has established a successful street triage team. The average monthly numbers of section 136 detentions across the NTW area in the 12 months before the establishment of the street triage was 71²⁰⁵. This number fell to 18 over the 4 months following. The initiative involves a team of dedicated officers and mental health nurses who work alongside each other and respond to individuals who come into contact with the police. They conduct an assessment of their needs and make sure the individuals receives appropriate mental health support. There is a strong emphasis on providing the highest quality of care with the ability to refer those in crisis to other appropriate agencies.

Use of police cells

We are recommending that police cells should be removed altogether as a place of safety in the Act by 2023/24. The reduction in use of police cells over the last year is welcomed, and we feel confident that there will be further reductions in 2018/19, because changes introduced in December 2017²⁰⁶ introduced a far more stringent interpretation of the "exceptional circumstances" under which police custody can be used. Now is the right time to take the next step and remove police cells as a place of safety altogether, and to ensure that people in crisis get the support they need from clinicians in hospital, without being

²⁰⁴ <https://www.college.police.uk/News/College-news/Documents/MoU>

²⁰⁵ <https://bmjopen.bmj.com/content/bmjopen/6/11/e011837.full.pdf>

²⁰⁶ to the Mental Health Act by the Policing and Crime Act 2017

subjected to the criminalising and traumatising experience of time spent as though they were under arrest. But, in order for this to happen, it is essential that mental health services are commissioned and resourced adequately so that they can properly perform their role, stepping in to the breach that police officers often need to fill.

The Review is also recommending a number of other changes that need to take place in the meantime to support a further reduction in the use of police cells. The Act should be changed so that it specifies that the preferred place of safety under sections 135 and 136 is defined as a “health based place of safety” or “section 136 suite”, as the current definition is too wide and unhelpful, and section 136 should be amended to allow a police officer to end the detention, for example on the advice of health professionals or a senior officer, in cases where it is clear a full MHA assessment is unnecessary.

Guidance from NHS England, NHS Improvement, the relevant health Royal Colleges and the Care Quality Commission should set out the minimum standards for section 136 suites, e.g. the physical environment, and staffing requirements and the need for psychological safety, and an audit of current provision against these standards should be undertaken as part of preparations towards removing police cells from the Act altogether. This audit should identify where new capital and revenue resources are required. NHS England and NHS Improvement should also undertake an audit of mental health assessment rooms in Emergency Departments to ensure that they are safe and suitable in line with existing guidance from the Royal College of Psychiatrists²⁰⁷ and the Royal College of Emergency Medicine²⁰⁸. Future capital funding that is made available by the government to the NHS should be invested to improve these assessment rooms/spaces where those improvements are needed, supported by NHS England, NHS Improvement and NHS Sustainability and Transformation Partnerships (STPs).

“MH Services are for those who need support in crisis; Police services are to support law and order. There should be much less overlap between the services.” – Carer²⁰⁹

We believe a national agreement is needed between mental health services and the police setting out how people detained under section 136 should be safely ‘handed over’ to health services, and the circumstances under which police officers may be required to stay at health settings (such as A&E) while this ‘handover’ takes place. We recommend that

²⁰⁷ <https://www.rcpsych.ac.uk/pdf/Standards%204th%20edition%202014.pdf>

²⁰⁸ [https://www.rcpsych.ac.uk/pdf/CEM6883-Mental-Health-in-EDs---toolkit-\(FINAL-FEB-2013\)-rev1.pdf](https://www.rcpsych.ac.uk/pdf/CEM6883-Mental-Health-in-EDs---toolkit-(FINAL-FEB-2013)-rev1.pdf)

²⁰⁹ Comment from Carer, Mental Health Act Survey, Centre for Mental Health

this should build on the Royal College of Psychiatrists' Standards on the Operation of Section 136 of the Mental Health Act 1983 (2011), and include an agreement that police will agree to remain in a health based place of safety where no agreement can be reached about the police leaving detainees in the care of NHS staff. Health staff must carry out an objective risk assessment process to determine when the police should leave. Where there are disagreements, the escalation process should include the police duty sergeant or inspector and an NHS manager (or on-call manager) working to reach agreement and resolve any dispute. In Emergency Departments, which are not necessarily set up for the purpose of section 136 assessments, the presumption should be that the police should stay to maintain the legal detention, until invited to leave by health staff.

Use of Ambulances

We are recommending that a recently convened multi-agency group involving the Association of Ambulance Chief Executives, NHS England, NHS Clinical Commissioners National Ambulance Commissioners Network and the College of Paramedics should establish formal standards for responses to 'section 136 conveyances' (where they should pick up and transport a patient from the police station to a hospital or a health based place of safety), and to all other mental health crisis and MHA non-emergency assessment calls. The standards should be equivalent to new ambulance response standards for physical health emergencies and reflect the principle of parity of esteem between physical and mental healthcare.

In advance of changes to the law and Code of Practice regarding conveyance, the relevant national bodies as mentioned above should support ambulance commissioners and providers to improve their section 136-related performance.

As part of the Long Term Plan, NHS England should invest capital and revenue to improve the ambulance fleet for mental health conveyance, to create new joined up functions between mental health services, ambulance services and other urgent and emergency care services, and to significantly expand the education and training of the paramedic and wider ambulance workforce in mental health. These vehicles do not need to be traditional emergency ambulances. Bespoke mental health crisis response vehicles would reduce the pressure on ambulance fleets, and provide a safe and appropriate alternative to full size ambulance vehicles.

We are also recommending that the Code of Practice is made clearer about those cases of extreme urgency or risk of violence in which police transportation may be preferable. For example:

- Where the delay in an ambulance arriving is so significant that it is in the detained person's interests to be moved by police vehicle.
- Where the person is displaying behaviour which is so resistant or aggressive that transfer in an ambulance vehicle would be potentially dangerous to the health and safety of the person or the professionals attending to them.
- Where the patient themselves requests this as a preference to minimise their own distress.
- In any situation where someone is transferred by police vehicle and an ambulance has attended the situation, one of the ambulance service personnel should travel in the police vehicle wherever possible.

Access to hospital following police detention

Section 140 of the Act makes it a responsibility of CCGs to ensure that arrangements are in place for the reception of patients in cases of special urgency. The operation of this responsibility needs to be discharged more consistently and more effectively, in particular to address the fact that people who are arrested under the criminal law are staying in police cells for too long, often unlawfully, after it has been established that they need to be admitted to hospital following a Mental Health Act assessment. NHS England and the CQC should work with CCGs, local authorities, the AMHP Leads Network and providers to understand how section 140 is being used on the ground and to issue clear joint guidance to allow NHS commissioners to discharge their statutory duties under this section of the MHA more effectively and consistently. NHS England and NHS Improvement should support commissioners and providers to recognise in their capacity and pathway planning that a number of Mental Health Act assessments take place in police custody, a proportion of which result in detention, and to consider how better to recognise and respond to these urgent cases. This planning work could be informed by AMHPs recording and sharing local data on the occurrence, cause or length of delays involved in transferring an individual from police custody to hospital under these circumstances.

NHS England Commissioning in Police Custody

Each police force is legally responsible for procuring their own healthcare provision for people in police custody. Following Dame Elish Angiolini's report on serious incidents and deaths in custody, the Government is considering moving the commissioning to NHS England. We would like to give this our full support. A transfer to NHS England would help introduce national NHS standards of healthcare to all police custody suites, and support the development of a service through which every service user can expect the same treatment or service, with oversight and regulation from the Care Quality Commission.

Police interactions with people from ethnic minority communities

The Organisational Competency Framework being recommended by this Review (see chapter on Experiences of People from Ethnic Minority Communities) should apply to police forces. The Crisp Commission (2016) made a recommendation to identify a clear and measurable set of Race Equality Standards for acute mental health services. Our recommended framework will help police forces identify what is required, and, together with local authorities and the NHS, and will hold local systems to account more robustly to improve overall outcomes for black people and other minority ethnicities. We are also recommending that a police/mental health Independent Advisory Group (or other appropriate approach) should be set up in each police force area.

Alongside this, the College of Policing should update its Equality Improvement Model to include a greater focus on mental health and ethnic minority issues for police forces to demonstrate progress against equality objectives. Additional data and research will be needed illustrate how people from different from backgrounds experience interactions with the police while ill. This must include qualitative studies, and service user involvement is crucial. This should complement our recommendations made in the chapter on Experiences of People from Ethnic Minority Communities.

What we are recommending

- **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.**

- **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.**
- **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.**
- **NHS England should take over the commissioning of health services in police custody**
- **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

People with mental health conditions involved in the criminal justice system (CJS) should have equivalence (availability, accessibility, acceptability and quality) of access to mental health care, outcomes, rights and safeguards to those of civil patients, whilst being mindful of the need to protect the public from further offending²¹⁰. But that is not the case: defendants appearing before the criminal courts, prisoners, and offenders in secure hospitals are all subject to delays in getting the mental health care they need.

Rates of self-inflicted deaths and self-harm in prison have been rising. There were 87 self-inflicted deaths in the year to June 2018, up from 78 in the previous year, and there were 49,565 incidents of self-harm, up 20% from the previous year²¹¹. In 2016, the Prisons and Probation Ombudsman found that 70% of prisoners whose death was self-inflicted between 2012 and 2014 had mental health needs²¹².

²¹⁰ The Royal College of GPs 2018 position statement is that prisoners should be 'afforded provision of or access to appropriate services or treatment,' which are 'at least consistent in range and quality with that available to the wider community'.

²¹¹ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/750582/safety-in-custody-bulletin-2018-q2.pdf

²¹² <https://www.nao.org.uk/report/mental-health-in-prisons/>

Criminal courts powers

We heard from members of the judiciary that magistrates' courts powers are limited compared with the Crown Court, despite the fact that all criminal cases begin in the magistrates' court, and more than 90% conclude there. Our recommendations would mean that mental health issues can be taken into account by the courts at the earliest opportunity, by giving magistrates' courts the power to seek assessments and remand defendants to hospital for treatment from the first hearing onwards.

Reducing remands to prison

People charged with a criminal offence often require mental health treatment. We heard from stakeholders that many people should have been diverted to hospital, but instead end up in prison and do not receive the care they need. We were concerned to hear that roughly half of the people being assessed for a transfer from prison to a secure hospital are remand prisoners who have not yet had their case determined by a court.

More worryingly, we heard that problems accessing treatment in the community, or finding available beds for remand to hospital, means that, in some cases, prison is considered 'a place of safety', especially where there is an immediate risk of suicide. On a number of occasions this has happened, despite court NHS Liaison and Diversion services identifying that the person needs admission, because a bed could not be found in time. In some cases, the courts are therefore left with no other choice but to remand defendants to prison for their own protection and welfare, even where the offence committed is relatively minor. We think that this should never have to happen.

Our changes will mean that the courts will no longer be able to remand a defendant to prison for their own protection and welfare on mental health grounds, but will instead have the power to send people straight away to hospital for the assessment and treatment they need. This is dependent upon adequate availability of hospital beds.

Speeding up transfers from prison to Hospital

Every year about 1,000 prisoners become so mentally ill that they need to be moved to a mental health hospital and detained under the MHA. We have heard that it takes on average 100 days²¹³ to transfer from prison to hospital, and during that time the prisoner's health is likely to be deteriorating. The MHA does not apply in prison, and so the only legal framework for treatment without consent for mental disorder is the Mental Capacity Act. Knowledge of this Act in prison is patchy, and the Mental Capacity Act has very different (and much more limited) treatment safeguards than are contained in the MHA.

We do not think that treatment without consent under the MHA should be extended to prisons, as that would be extending use of coercive detention not because it is legally required, but to fix practical problems that prevent patients getting speedy access to treatment in a hospital. Delays in transfers from prison to secure hospitals must be reduced. There are several differences between the processes for admission from the community and from prison. In particular there are no statutory time limits for assessment or admission; there is no AMHP or equivalent independent role to manage the assessment and admission process; and there is no agreed definition (between prison clinical teams and hospitals) of what constitutes an urgent need to transfer. Although there is a time limit set out in DHSC Good Practice²¹⁴ for transfer to take place 14 days after the first assessment, only 34% of prisoners were transferred within this timeframe in 2016-17, and 7% (76 people) waited for more than 140 days²¹⁵. The House of Lords Joint Committee on Human Rights, in their recent interim report on mental health and deaths in prisons, called for a legal maximum time between diagnosis and the transfer²¹⁶.

We heard from NHS England and Her Majesty's Prisons and Probation Service that there are considerable delays and perverse incentives in the current system for transferring prisoners to secure hospitals. There were delays in waiting for the first assessment (an average of 32 days) and between the first and second assessment (an average of 34 days)²¹⁷. We believe that a lack of clarity over when the clock starts gives staff the opportunity to manipulate the timeframe for processes like assessments, for example it was suggested to us that clinicians are waiting for a bed to become available first. Psychiatrists can find it difficult to get access to the prisoner to carry out assessments. We

²¹³ From the point at which an assessment was first requested

²¹⁴ <https://www.gov.uk/government/publications/the-transfer-and-remission-of-adult-prisoners-under-s47-and-s48-of-the-mental-health-act>

²¹⁵ NAO report on Mental health in prisons

²¹⁶ <https://publications.parliament.uk/pa/jt201617/jtselect/jtrights/893/893.pdf>

²¹⁷ <https://s3.eu-west-2.amazonaws.com/nhsbn-static/Other/2018/Data%20Transfers%20and%20Remissions%20Census%20Report.pdf>

are recommending a new role is created to oversee the process of assessment and admission, that is independent of both the prison and the NHS, similar to that of AMHPs for civil patients. In line with Care Act responsibilities, this role could be commissioned by the local authority in which the prison is based. The involvement of this independent role will unblock the institutional barriers and make sure the patient's needs come first. Giving the process new statutory timeframes will give this new role the teeth it needs to push the transfer through. The CQC and the Her Majesty's Inspectorate of Prisons should oversee compliance with the new process and timeframes, and the receiving hospital's role in facilitating timely admission.

We know that the prison population has an over representation of the Black British population compared to the general population²¹⁸. We also know that there is similar over-representation of minority ethnic community patients in low and medium secure hospitals. This means that any improvements to waiting times for transfer should be of particular benefit for minority ethnic community prisoners.

Justice Secretary Powers

For patients who are detained in hospital subject to a 'restriction order', imposed by the courts, the responsible clinician must seek the consent of the Justice Secretary, via the Mental Health Casework Service (MHCS) in Her Majesty's Prison and Probation Service to allow the patient leave, to transfer the patient to another hospital or to discharge the patient. The Justice Secretary may also add a 'restriction direction' when he transfers prisoners to hospital under the MHA, which has the same effect. We heard from numerous sources that this causes considerable delays (we heard from one patient who waited 150 days for a decision). We heard of cases where the delay was as long as a month for transfer to a hospital with the same level of security. What is most surprising is that the vast majority of applications are granted (for example 97% of requests to move to a lower level of security), bringing in to question the need for such onerous and time-consuming application processes.

²¹⁸ At 30 September 2018, Black or Black British people accounted for 12.5% of all prisoners, but they make up 3% of the population of England (according to the 2011 Census).
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/751948/population-q2-2018.ods

We heard from MHCS that there had been a recent increase in the time taken for decisions to be made, that related to a sudden drop in staff numbers which created a very large backlog. We have accepted that this was unavoidable, and that timeframes are now shorter, and have improved from the years prior to the large backlog in 2017²¹⁹. We were also informed that MHCS has been working with the NHS on a joint improvement programme, seeking to speed up decision-making.

However, we believe that the time taken for decisions is still too long and will add to patients' overall length of stay. This has a disproportionate effect on black people who are more likely than their white counterparts to be detained under Part III of the MHA. Our changes would mean that the MHCS would use information within the new CTP (see the earlier section on new statutory Care and Treatment plans) to allocate each patient into a category reflecting the level of complexity surrounding the decisions to be made (in a similar way that offenders are already categorised within the Probation and Prison services). For decisions that are straightforward or carry little risk (for example transfer to another hospital with the same level of security) the responsible clinician would take the decision, giving notice to the MHCS who would have 14 days to object. On the other hand, a small number of patients who are considered to be particularly high risk for whatever reason would continue to be managed directly by the Secretary of State for Justice as before. So for the vast majority of cases where there is agreement (e.g. 97% of transfers) the only real change would be that the process be speeded up, making more beds available for prison transfers. A less satisfactory solution might be if the Ministry of Justice implement mandated timescales for decisions to ensure that the previous history of long delays becomes a thing of the past.

The CTP would also be used to set out what should happen if the patient needs to be readmitted. This should cover all options including informal admission, use of civil sections, or recall by the Justice Secretary. It should specify under which scenarios a recall may be justified (for example if the patient has been refusing to take his medication, has a history of relapsing swiftly and becoming violent against others when unmedicated, and is showing signs of relapse). This would enable the patient to know what to expect, and would help them to be able to make their case where recall is not justified.

²¹⁹ For example making decisions on escorted community leave is currently decided within an average of 18 days for example a transfer to a hospital with the same level of security is currently decided within an average of 12 days

Tribunal powers

MHCS is not the only body that can order the discharge of a ‘restricted’ patient. The Tribunal can do this on application by the patient, but they are unable to direct leave or transfer to another hospital. We think this should change.

We also think that some checks and balances need to be brought in to make sure patients are not held under unnecessary restrictions in the community as part of a conditional discharge. This can be for years or decades after they are released from hospital, often for far longer than any prison sentence would have been. And people on a conditional discharge often have a range of complex needs, making it more unlikely that they are able to use their right to apply to the Tribunal for an absolute discharge. For this reason, we think that an automatic referral should be made to the Tribunal every year then at regular periods after that to make sure the restriction is still needed.

We are aware that a recent ruling by the Supreme Court²²⁰ means that patients cannot consent to conditions attached to their discharge from hospital, if the conditions in effect deprive them of their liberty (if the conditions mean that they are under continuous supervision and control and not free to leave). In some cases, discharge plans, particularly ones that are there to protect the public, fall into this category.^[1] This means that it is now much more difficult for these offenders to be released on a conditional discharge, and that people may be staying in hospital even when they are well enough to leave, because the risk they present can only be managed in the community in conditions that amount to a deprivation of liberty. Given the Supreme Court judgment, we suggest that 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. If a solution is not found, the numbers of offenders held in hospital will continue to rise because they are unlikely to get out again. Not only is this clearly wrong for the individuals concerned, it also means they are taking up valuable bed space, and obstructing efforts to transfer people in from prison.

²²⁰ Secretary of State for Justice v MM [2018] UKSC 60

^[1] i.e. they are more restrictive than the examples set in case law by the Supreme Court in Cheshire West

Parole Board

Some patients held in secure hospitals have criminal sentences that mean their release back into the community can only be agreed by the independent Parole Board which covers England and Wales. This is a separate process that can only take place after the Tribunal has recommended discharge. We heard that there can be delays of many months, and sometimes years, between a Tribunal recommending discharging a patient and release via the Parole Board. These delays are unacceptable. MoJ and the Parole Board have set out steps they are taking to streamline the process which is a positive start. But, many stakeholders have argued that the processes and hearings should be combined so that one panel considers both discharge from hospital and release from criminal custody. We understand that this is not possible at the moment because the Parole Board is an Arm's Length Body and not a Court or a Tribunal (which would enable cross-ticketing of judges into different jurisdictions). We think the Government should consider combining the powers and role of the Parole Board with the Tribunal. We believe there will be no loss of expertise, so long as there is a judicial chair, and there might be a saving of time and resources which would justify the additional administrative burden.

Risk Assessment

Throughout the Review we heard that understanding the defendant's level of risk is key to each of the decisions along the criminal justice pathway. But we also heard that each decision, and each decision maker, looks at risk differently. For example, the psychiatrist preparing a report for the criminal court will take different risk factors into account than the judge will when sentencing; the Ministry of Justice will take a different approach to risk to that of the Tribunal; and prisons will categorise people in a different way to secure hospitals. This is unfair on the patient, and the mismatch of information sought by one party and the information provided by another can lead to uninformed decision making. We are recommending that there is one recognised method of assessing risk across all decision-making processes.

What we are recommending

- **Magistrates' courts should have the following powers, to bring them in line with Crown Courts:**
 - **remand for assessment without conviction under section 35 of the Mental Health Act (MHA)**
 - **remand for treatment under section 36 of the MHA**
 - **the power to commit a case to the Crown Court for consideration of a restriction order following an 'actus reus' finding**
 - **the power to hand down a supervision order following an 'actus reus' finding (where a person is not fit to enter a plea, but has been found to have committed the offence) under S1a of the Criminal Procedure (Insanity) Act**
- **Prison should never be used as 'a place of safety' for individuals who meet the criteria for detention under the Mental Health Act**
- **A new statutory, independent role should be created to manage transfers from prisons and immigration removal centres**
- **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).**
- **Decisions concerning leave and transfer of restricted patients should be categorised by the Ministry of Justice according to 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.**
- **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;**
- **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.**

- **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**
- **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.**
- **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**
- **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

Immigration detention is known to have a negative impact on mental health. Some detainees have pre-existing mental disorders or a history of trauma and are particularly vulnerable²²¹. This is reflected in the Detention Centre Rules²²² which require detention medical practitioners to report to the Home Office where they have concerns, including for detainees that are survivors of torture, so that the detainee's ongoing detention can be reviewed. Immigration detention is not part of a criminal sentence, but we heard that a

“lack of awareness of the differences between detainees in the criminal justice system and immigration detainees often results in detainees not receiving the most appropriate treatment in the most appropriate setting²²³”.

We heard that even when a detainee is willing to be treated, detainees are transferred to secure hospitals and held under section 48 / 49 of the MHA. Not only is this a grossly disproportionate use of restriction (except perhaps in relation to foreign national offenders), it puts unnecessary pressure on secure beds, and subjects detainees to the same delays

²²¹ <https://www.gov.uk/government/publications/review-into-the-welfare-in-detention-of-vulnerable-persons>

²²² <http://www.legislation.gov.uk/ukxi/2001/238/article/35/made>

²²³ Submission from the Helen Bamber Foundation

in getting treatment as outlined earlier concerning prisoners. The mission statement of Royal College of Psychiatrists²²⁴ states” *“It is also inappropriate for detainees (who are not prisoners) whose illness is so severe that they really do require hospitalisation, but who are willing to be admitted and treated, to be admitted under Mental Health Act section 48/49 provisions. This is clearly not the least restrictive option that meets their mental health care needs. Where compulsory assessment and/or treatment is necessary, the most appropriate option will normally be release from immigration detention and admission on sections 2 or 3 of the Mental Health Act, since hospital detention is subject to appeal and also enables appropriate discharge planning (including day leave), as well as continuity care once hospital admission is no longer necessary. Good mental health care means providing healthcare in a least restrictive environment with avoidance of inhuman treatment.”*

The independent role we are recommending for prison transfers should also manage the transfer process for immigration detainees, but, for immigration detainees, this would also include considering the least restrictive option for treatment. We would expect this to involve making recommendations to the Home Office regarding release and considering alternative treatment pathways, including treatment in the community, voluntary admission and civil sections of the MHA. Care would need to be taken to identify where the detainee is a foreign national offender, as the consideration or risk may be different. For these cases, there would need to be close working with Home Office officials.

What we are recommending

- **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**

²²⁴<https://www.rcpsych.ac.uk/pdf/Satisfactory%20Treatment%20in%20Detention%20document%20December%202015%20edit.pdf>

VICTIMS

The interests and needs of those with severe mental illness, and those of victims are often the same. Many people with mental disorders are themselves victims, often as a result of stigma, social exclusion and discrimination. Mistreatment and abuse in childhood is now clearly linked to increased rates of serious mental illness in adult life, and people with mental health problems are more likely to be a victim of crime than the general population²²⁵. Sadly, in some instances the cycles of deprivation, exclusion, poverty and neglect can lead to a person being both a victim and perpetrator²²⁶. But it is not true to say that serious mental illness poses no risk to others. It does - albeit small, and largely linked to substance misuse²²⁷. In addition, the numbers of homicides committed by people with a mental disorder has decreased a little over the last three decades

We also want to improve support for people who have become victims of serious offences committed as a result of mental disorder. We agree with the recent report of Baroness Newlove, the Victim Commissioner²²⁸, that stated that victims of mentally disordered offenders should get greater recognition. The victims and families of victims of mentally disordered offenders are just as affected as those for whom the offender enters the mainstream criminal justice system, by the circumstances of the offence, and the legal processes that follow.

We know there is a gap between the level of information victims receive from Her Majesty's Prisons and Probation Service when the offender is a restricted patient, compared with information from hospitals concerning unrestricted patients. We were concerned to hear of instances where victims have not been given adequate information. We welcome the statements in the recently published Victims Strategy²²⁹ "to address any improvements that need to be made to entitlements for victims of mentally disordered offenders in the updated Victims' Code". We are recommending that the Department of Health and Social Care, and the Ministry of Justice, work together to remove this gap in provision.

²²⁵ <https://www.victimsupport.org.uk/sites/default/files/At%20risk%2C%20yet%20dismissed%20-%20summary.pdf>

²²⁶ Crush et al 2018

²²⁷ Psychosis and suicide, Pamela J Taylor and Natasha Kalebic

²²⁸ <https://s3-eu-west-2.amazonaws.com/victimscmm-prod-storage-clhgxgum05k1/uploads/2018/08/Victims-of-MDO-report.pdf>

²²⁹ <https://www.gov.uk/government/publications/victims-strategy>

We have not recommended that victims should be able to make a Victim Impact Statement to the Tribunal, because this can already be done (if the statement addresses the nature of the patient's condition). We do think, though, that all victims need to be made aware of this.

What we are recommending

- **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

There are a number of areas where improvements are needed across the system so that our Recommendations will have the best chance of success. Chief among these is the need for the sector to commit to co-production of services at all levels. Other important enablers include improving data collection and how they are used, digitalising parts of the MHA process, and, crucially making improvements to staffing and staff experience. We have set out our thoughts in this chapter, with a number of further recommendations for taking these system-wide enablers forward.

DATA

The NHS 2016 ‘Five Year Forward View for Mental Health’ called for a “data and transparency revolution”, but so far there has been no revolution for Mental Health Act data. The way MHA statistics are collected by the NHS Digital changed in 2016/17, but we understand that there are flaws in both the previous dataset, and incomplete data in the current one²³⁰. This leaves a troubling sense that nobody can accurately articulate how use of the MHA has changed, and is changing, over time. This is clearly unacceptable. Good data is urgently needed so that trends within the performance of providers can be monitored, and so that use of MHA powers can be considered alongside data from other secondary mental health care services to identify particular pressure points.

Outside of the NHS, data collection is patchy. There is no national dataset for the work of AMHPs. This exacerbates the feeling AMHPs have shared with us that they are often working unsupported and the issues they encounter are relatively invisible. AMHP data is collected for local authorities, but we have heard this is rarely used by local authorities or their local partners to inform planning and improvements. Data does exist which could help; a snapshot audit undertaken in 2017/18 by Association of Directors of Adult Social Services together with NHS England and the NHS Benchmarking Network provided new and critical insights into assessments for detention under the MHA, for example, into trends in the location of MHA assessment requests, the time of day of requests, the length and perceived reasons behind delays, demographic information and assessment outcomes.

²³⁰ the NHS Digital Mental Health Services Data Set (MHSDS), which relies on individual providers providing accurate data

There are a number of different public sector bodies involved in the MHA, and a number of potential data sources. These include the NHS Digital Mental Health Services Data Set (MHSDS), the Home Office Annual Data Requirement (ADR) (covering use of police powers to detain under the MHA), and data from local authority AMHP services, which is not currently collected or reported nationally. Each collects data from different geographical footprints over different timeframes. Sharing of data between local partners is left to discretion and there is a lot of variation. This means that policymakers, local decision-makers, academics and the public do not have an opportunity to understand how the Act is used and in what context. Because of this, the Review has struggled use or generate its own reliable strong evidence and this must change.

There is no standardisation of ethnic categories across different datasets, so comparison of data by ethnicity is difficult. the NHS Digital MHSDS dataset contains six broad categories (White, Mixed, Asian or Asian British, Black or Black British, Other, Not Stated/Known), the Home Office ADR contains four broad categories (White, Black, Asian, Chinese & Other), and the AMHP activity snapshot audit contained three or four broad categories (White British, White Other, Black/Black British, Other/Mixed). We recognise this is likely to be the case across many more public, private and academic datasets.

NHS MHA data

We are recommending that NHS England, NHS Improvement, the CQC and NHS Digital, supported by the Department of Health and Social Care, should work together to establish an agreed, accurate national baseline of use of the MHA. In advance of this, pilot areas should be funded to develop a robust methodology which could then be rolled out nationally. We suggest these pilots should be in areas that have high ethnic minority populations.

Providers should be supported to improve the completeness and quality of the data they submit to the NHS MHSDS. We are aware that NHS England is doing work to improve the quality of MHSDS data, and MHA data should be prioritised as part of that work. Key data from the MHSDS should be published monthly as close to real time as possible.

AMHP data

The DHSC should work with local government stakeholders such as ADASS, the LGA, the AMHP Leads Network and NHS Digital to establish a new official national dataset of AMHP activity. This should be informed by the snapshot audit undertaken by the NHS Benchmarking Network and should include timestamps to help highlight delays in MHA assessment processes. In the interim, while this is being set up, the snapshot audit should be repeated.

Policing data

The Home Office in liaison with the National Police Chiefs Council currently publishes data on police use of detention powers under the MHA (sections 135 and 136) annually with a 6-month time lag. We recommend that this should be published on a quarterly basis as close to real time as possible, and should include new data on delays so that opportunities for in-year improvements are not missed. This will support our recommendation in the Policing and the MHA chapter to eliminate the use of police custody for adults, and to drive down the use of police vehicles for transporting patients.

Bringing the Data Sets Together

We are recommending the establishment of a national MHA data hub, to pull together and routinely analyse MHA data across NHS funded services, local authorities and policing as close to real-time as possible. To get the most out of the data sets, information about individuals should be linked together wherever possible in line with data security law and information governance guidelines. Outputs should be shared with local strategic partnerships, such as Sustainability and Transformation Partnerships (STPs) and Health and Wellbeing Boards, to support their planning and commissioning decisions.

Collection of ethnicity data

Standardisation of ethnic data sets would improve our understanding of the overrepresentation of ethnic minority groups. It would also help us to understand the level of sociocultural bias. We are recommending that the NHS Digital, the Home Office / policing and local authorities should work towards standardising ethnicity categories. This would make their data on ethnicity comparable, making it easier to map out experiences of those from ethnic minorities across the different public services. NHS ethnicity data on access to primary or secondary mental health services could be compared with MHA data, and police ethnicity data. This may require longer term efforts on a much wider scale across government and all public bodies.

Ethnicity data reported by police forces on the use of section 136, use of force and other powers of arrest should be routinely analysed by the Home Office and National Police Chiefs Council. This should be compared with population data to highlight any disproportionality that affects people from ethnic minority backgrounds experiencing a mental health crisis and to inform actions required to address this where necessary. These analyses should be published transparently.

We also think that more should be done to make sure that data on other disadvantaged groups is collected, to build a better picture of how they experience the MHA. This

includes, but isn't limited to, LGBTQ+, asylum seekers & refugees, learning disabilities, Autism, children, young and older people. The Government should also try to understand how people marginalised by socio-economic factors (for example homeless people) are disproportionately affected by the MHA.

What we are recommending

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

The Five Year Forward View for Mental Health noted the pivotal role digital, data and technology could play in driving major improvements to mental health services, and we believe that includes care provided under the MHA. This includes helping to make sure that care is delivered consistently between different settings, and supporting the effectiveness and efficiency of services and staff. Unfortunately, the majority of MHA-related activity is still carried out using paper-based systems, for example, assessment forms, medication or leave forms, or the provision of information about the Act to patients. This means that information is often incomplete or inaccessible to patients and staff, so there is a greater risk of more mistakes being made because of human error, and patients and carers are provided with less information. Professionals and patients have told us that care records are often difficult to find, making them inaccessible at key times. Patients and

their carers have also told us they have been told about care plans they did not even know existed.

Digitising the MHA

A small number of trusts, among them the Mental Health Trust Global Digital Exemplars, are working to develop digital processes to support Mental Health Act services. The Review supports this work which should lead to a number of significant benefits to patients in line with our proposed new principles. In particular, we think digital enablers could provide patients with a modern and consistent way to access information about the Act, their rights, safeguards and treatment processes. As well as reducing delays (including during the assessment process), the availability of real-time information and digitisation could maximise the time professionals can spend with their patients. Clinicians and patients could also have access to care records, care plans, treatment preferences and advance choice documents (ACDs), and the details and wishes of nominated persons. Clinicians could use digital tools to be given electronic prompts to check physical health and carry out observations or assessments before tribunal deadlines. When they return to the community, patients could benefit from digital access to information, self-care tools and easily navigable forms of clinical and non-clinical support. It would also assist the work of the Tribunal service, who rightly complain that they are not always informed in time of cancelled hearings, saving time and expense.

We are recommending that 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 supported by relevant changes to the Act and Code of Practice. Additional funding should be made available to expand the exemplars, specifically in relation to detained patients and their outcomes. The exploration of new approaches should include people with lived experience of detention, local authority stakeholders given the primacy of AMHP services to MHA processes, and the CQC.

What we are recommending

- **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.**
- **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 AND MONITORING

This report sets out the many areas in which we think improvement is needed. There are a number of areas across the NHS that have seen the benefit of implementing Quality Improvement (QI) programmes, but this approach has not yet been attempted with the MHA.

A new national Quality Improvement Programme for the Mental Health Act

We are recommending that, in order to give our recommendations the best chance of success, a national QI programme should be set up focussing on MHA processes. This should take learning from existing national and local QI programmes such as the NHS Improvement, CQC and NCCMH Reducing Restrictive Practice collaborative. The new national programme should include clinical leaders, local authority AMHPs and social care professionals, patients and carers, and should focus on implementation science and methodologies. Once developed and tested, the programme should be adopted by all mental health providers and local systems, and should inform a refreshed regulatory approach to the MHA in the longer term by the CQC focused on improvements rather than processes.

The QI programme should empower clinicians, ward staff and people with lived experience to take ownership of, and benefit from positive change, through improving people's experiences of assessment and detentions under the MHA. It should also encourage practice to become aligned with the new principles we are recommending in this report, with a particular focus on patient involvement and addressing inequalities. The outcomes we would want to see include, but are not limited to: improved care planning; reduced inequalities (through, for example, systematic involvement of people with protected characteristics); improved partnership working; improved assessment processes; and greater levels of safety, dignity and respect experienced by service users. This would include national benchmarking on how the Act is used by trust, by region, including inequalities. The national QI programme would work closely with the CQC and include benchmarking rates of use of the Act, as well as absolute numbers. In time, all use of the Act would be transparent and subject to QI processes and activity.

Leadership of this programme should involve service users and carers. National NHS and local authority bodies should explore how a new approach could be replicated locally, including establishing a leadership programme for service users and carers so they feel supported, trained and able to contribute fully to local improvement efforts. AMHP input would be integral, particularly to pick up delays and waiting times within assessment processes. Over time, ambulance services and police forces should also become involved.

We also think that DHSC and national bodies should discuss how the MHA monitoring role of the CQC²³¹ may be extended to cover assessment of how the Act and Code is working in local areas. This would be consistent with their evolving regulatory role in looking at the quality of care, pathways and integration within a place or local area²³². This would enable them to look more widely at the operation of the Act and make cross-cutting recommendations and proposals. The one exception to this should be independent providers of IMHAs for whom CQC monitoring may represent too big a burden. The CQC will be able to consider the services provided by these organisations through the local authorities that commission them.

What we are recommending

- **NHS Improvement and NHS England should fund the establishment of a national Quality Improvement (QI) programme relating specifically to the Mental Health Act.**
- **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

The role of both doctors and social workers has been set out in legislation since the 1959 Act, ensuring that the importance of both medical and social welfare is never lost. This includes the important role of nursing staff, particularly where they are both nurse consultants and responsible clinicians. But we are aware of problems across the board with recruitment and retention.

Many of the recommendations in this report depend heavily on the staff who work within our services. Their dedication, compassion and expertise play an essential part in the patient's treatment and we know their working conditions are often very difficult. Services that are underfunded and overcrowded, with high turnover and vacancies adding to the challenges. We would like to reinforce the messages in the NHS Five Year Forward View

²³¹ Section 120, A-D

²³² <https://www.cqc.org.uk/what-we-do/coordinated-care/coordinated-care>].”

– without a positive change in this direction, it is unlikely the aims of this Review will be achieved.

Equally, we want to see staff who are working in mental health care, and particularly on inpatient wards, with the right experience and training, with an understanding of the Act, the new principles and the Code of Practice and a knowledge of the rights of patients detained under the Act. The current Code of Practice outlines that this should already be the case but consecutive CQC reports indicate that this is very far from reality. We want to see promotion of a model of leadership that is based on reflective practice and shared-decision making, and which takes responsibility for ensuring wards are therapeutic.

Approved Mental Health Professionals (AMHPs)

The Approved Mental Health Professional (AMHP) is responsible for making applications for detention. This is a key role within the MHA, with legal responsibilities to organise and lead mental health act assessments, using a social, rights based, least restrictive model. Local Authorities are required to provide enough AMHPs to operate a 24hr service in each region, but we have heard that most areas are struggling to provide enough AMHPs to meet local need. The 2017 NHS England Benchmarking and ADASS mental health social care national report²³³ showed that there were 3,250 qualified AMHPs working in mental health services, a reduction from previous surveys, and that urgent or community assessments were delayed in 15% of cases due to a lack of staff. The CQC reported in 2018²³⁴ that AMHPs in all areas are working long hours and under intense pressure.

We think that the LGA, ADASS, AMHP leads network, NHS England, HEE and DHSC should agree updated guidance on the appropriate number of AMHPs for the successful operation of the MHA and ensure that Local Authorities and Integrated Care Systems have the ability to fulfil this. This will need to be incorporated into an AMHP workforce plan to be implemented by Social Work England and part of the integrated workforce plan for mental health services. We also think that the government should consider developing MHA Regulations that outline AMHP training and professional regulations developed by HEE.

²³³ <https://www.adass.org.uk/media/6428/nhsbn-and-adass-social-care-national-report.pdf>

²³⁴ https://www.cqc.org.uk/sites/default/files/20180326_mha_amhpbriefing.pdf

Section 12 Doctors

We have heard from many stakeholders, including AMHPS, the police, and the criminal courts, that there are problems with getting assessments carried out by doctors approved under section 12 of the MHA, and in many cases this leads to delay. AMHPS and courts are often left to 'dial around' looking for doctors over the phone.

As with AMHPs, there appear to be multiple reasons for this relating to supply and demand as well as logistics. Many parts of the country struggle to find doctors who can and are willing to perform this function, perhaps linked to the payments they receive, and there is an over-reliance on retirees. Two doctors are required to do an assessment, and another barrier to finding suitable doctors is that one of these is required to know the person concerned, if practicable. It may be appropriate to review this requirement, particularly if knowledge of the patient has little impact on the nature of the medical recommendations they make.

Traditionally section 12 doctors have been paid per assessment by CCGs on a 'freelance' basis. Some CCGs have told us that the payments process is arduous and unclear, and they prefer Trusts to make arrangements for their doctors to be section 12 approved so that assessments are made as part of a core team function, such as a doctor working as part of a crisis team. This would also address potential conflicts of interest, and some issues around pensions and revalidations.

We are recommending that the Department of Health and Social Care, NHS England, NHS Clinical Commissioners, ADASS, the LGA, Social Work England, the AMHP Leads Network and other relevant professional bodies such as the Royal College of Psychiatrists, the Royal College of GPs, and the British Medical Association should review and address the factors that affect the timely availability of section 12-approved doctors and AMHPs. This should include consideration of whether it would be appropriate and safe to introduce a minimum waiting time standard for the commencement of an MHA assessment.

What we are recommending

- **The factors that affect the timely availability of section 12-approved doctors and AMHPs should be reviewed and addressed.**
- **The government should consider introducing a minimum waiting time standard for the commencement of an MHA assessment.**

Improving Staff Morale

While information on staff experiences is available across the NHS, the data for mental health services does not appear to have been systematically interrogated. There are also mechanisms for capturing and analysing patient experiences, but this information is not routinely and transparently available. Measures that are currently reported nationally, such as the Friends and Family Test, are inappropriate for people who have been detained under the Act.

Exploring the link between staff morale and the patient's experience

According to NHS England²³⁵ “[t]here is compelling evidence²³⁶ which suggests that improving staff experience has a tremendous impact on patient care and on resources.” So there is no dispute that organisations should look after their staff, not only so that they can hold on to them, but also so that they can give the best care to their patients. Although some pioneering work has been carried out to create cultures of compassionate care and wellbeing²³⁷, and to explore the relationships between staff engagement and NHS performance²³⁸, it’s fair to say that these have still not been sufficiently exploited in the mental health settings. For example, people should make more use of programmes such as the prisons and probation service “Enabling Environments” These are an organisational and psychosocially informed approach based on both theory and evidence, and accredited by the Royal College of Psychiatry²³⁹. All probation hostels are on route to achieving accreditation²⁴⁰. We think that it is important that mental health services follow this lead.

This approach should be expanded to include acute inpatient mental healthcare. We are recommending that NHS England and NHS Improvement work with mental health service providers to explore whether the evidence linking staff morale and patient experience is applicable to detained inpatients. This should include exploring with partners²⁴¹ how creating positive staff experiences and organisational cultures can improve the quality of care for people detained under the Act.

²³⁵ <https://www.england.nhs.uk/blog/caring-for-people-who-care-really-matters/>

²³⁶ <https://www.england.nhs.uk/publication/links-between-nhs-staff-experience-and-patient-satisfaction-analysis-of-surveys-from-2014-and-2015/>

²³⁷ <http://www.ihl.org/Topics/Joy-In-Work/Pages/default.aspx>

²³⁸ <https://www.kingsfund.org.uk/sites/default/files/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf>

²³⁹ <https://www.rcpsych.ac.uk/PDF/EE%20Standards%20-%202013.pdf>

²⁴⁰ <https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2017/07/Probation-Hostels-2017-report.pdf>

²⁴¹ such as the Point of Care Foundation

What we are recommending

- **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.**

THE APPLICATION OF THIS REVIEW IN WALES

The MHA applies to both England and Wales. This is complicated because health policy is separated between the UK Government and the Welsh Government (where health is devolved), whereas justice (including criminal justice and Part III of the Act) is not. This means that our recommendations cover England for Health (although we have aligned them with Wales policy and practice wherever possible), but both England and Wales for justice. We have learned during this Review that the Mental Health Review Tribunal²⁴² for Wales (MHRTW) does not quite fit into either category. As the Law Commission has observed when announcing a new Welsh law reform project on tribunals, ‘the rules and procedures governing Tribunals in Wales have developed piecemeal from a wide range of different legislation. Much of the legislation was developed outside the devolution process, resulting in gaps in the legislation’.

There are a number of differences between the English and Welsh Tribunals. Each has their own set of rules. Some of our recommendations rely on a Tribunal judges sitting on their own (for example to hear the appeal against treatment decisions). The rules in England specifically allow this to happen, whilst Welsh rules do not. And, because of the legislative anomalies mentioned above, it is not clear who is able to make this amendment to the Welsh rules. In addition, many of the Tribunal judges in England are full time salaried staff, whereas in Wales the MHRTW members (with one exception) are paid a set fee for each hearing. This can make it difficult to guarantee their availability²⁴³. We understand judges sitting at the Court of Protection in Wales could be ‘cross ticketed’, i.e. given the jurisdiction of the MHRTW, so that they could provide additional numbers to deal with the ‘judge alone’ work that we are recommending. We also understand that England and Wales are able to loan each other Tribunal members. We hope that this may mean that our recommendations concerning Tribunal powers and procedures may be accepted in Wales.

²⁴² Throughout the review, where we use the word Tribunal we are referring to both the First Tier Tribunal in England and the Mental Health Review Tribunal for Wales

²⁴³ Currently, there are 24 legal members 50 medical members and 32 lay members who in 2017-18 dealt with 2028 applications

We also understand that in 2019 the Law Commission review²⁴⁴ which will look at a number of issues including the appointment and of Tribunal judges and other members and the power to make and standardise procedural rules and we welcome this. We hope this will lead to changes that enable any changes to the MHA to be applied in the same way across England and Wales. This is important because we do not want patients in Wales, who are subject to the same MHA powers as patients in England, having different levels of access to the MHRTW. It is also important because, due to the types of beds required (for example medium secure forensic beds, many of which are in Wales) many of the patients in Welsh hospitals come from England, and vice versa.

²⁴⁴ <https://www.lawcom.gov.uk/new-welsh-law-reform-project-on-tribunals-announced/>

THE FUTURE DIRECTION OF TRAVEL – FUSION OF THE MHA AND MCA

We have set out earlier in this report that we think there is still a need for a MHA. We have also set out where we think the dividing line is between the MHA and the MCA. In our interim report, we said we would consider whether or not the MCA and the MHA should be ‘fused’ together as a longer-term option. We were also specifically asked to consider this issue by the Government as part of its response to the 2017 Law Commission report into Mental Capacity and Deprivation of Liberty.

The question of ‘fusion’ has been raised by many stakeholders during the course of the Review. There are two possible, but quite different, legal models which people have in mind when they talk of fusion:

1. The first is to keep the MHA separate from the MCA, but make use of MHA powers dependent, either largely or entirely, on the ability of the person to make their own decisions concerning their treatment. In Scotland, the patient’s ability to make decisions concerning their treatment must be significantly impaired because of their mental disorder.²⁴⁵ The Indian Mental Healthcare Act passed in 2017 is much more radical because it broadly relies on a capacity test for both detention and treatment;
2. The second is to replace the MHA and MCA with a new Act that ‘fuses’ the two together, and makes all forms of care and treatment dependent upon mental capacity. In other words, either the person must consent, or care and treatment has to be provided to them on an alternative basis. This has been done within the Mental Capacity Act (Northern Ireland) 2016 which has been passed, but has not yet been implemented. The Northern Ireland Act allows people who lack capacity to be treated on a “best interests” basis.²⁴⁶

²⁴⁵ See the Mental Health (Care and Treatment) Act 2003.

²⁴⁶ It would be equally possible to provide another basis to “best interests,” which the Committee on the Rights of Persons with Disabilities finds problematic. The Assisted Decision-Making (Capacity) Act 2015 in Ireland (again, enacted, but not yet in force) sets out an alternative framework, more closely tied to the language of Article 12 of the CRPD. Ireland will retain separate mental health legislation, so this Act does not represent a fusion model.

This report has set out a number of ways we want to increase the attention paid to a patient's mental capacity under the MHA. The overarching aim of this Review is increasing respect for the choices made by people about their treatment. Someone's ability to make decisions, or be supported to make decisions, is key to this. That is why we have proposed aligning MHA decisions with the best interests test contained in the MCA 2005. We considered including the Scottish concept of 'significantly impaired decision-making ability' ('SIDMA') into the detention criteria but, were concerned that this might cause confusion between SIDMA in the MHA and mental capacity under the MCA. We were also not persuaded that the introduction of a test such as SIDMA would significantly reduce detention.²⁴⁷

We have considered the arguments in favour of taking the much more radical step of fusing mental health and mental capacity law together in the long term. We accept there is a strong argument in principle that maintaining separate mental health and mental capacity laws can lead to discrimination towards those with mental health problems. We recognise the human rights arguments in favour of fusion. As powerfully put by Lady Hale, President of the Supreme Court, fusion:

*seems [...] to come closest to reconciling our conflicting international human rights obligations. It is predicated on respect for human dignity and autonomy and individual values and preferences. It does not discriminate between the treatment and care of physical and mental disorders. It covers all kinds of decision-making*²⁴⁸

Fusion would also make it easier for people on the ground, as they would no longer have to find their way around the complex overlap between the two Acts and few would doubt that this would be an improvement. Our Review has recommended a new 'dividing' line around objection to admission and/or treatment (see the 'Deprivation of Liberty: MCA or MHA?' section) that should reduce the complexities, but the reality is that they will remain as long as the two pieces of legislation co-exist.

²⁴⁷ Although the use of detention under the 2003 Act in Scotland was initially significantly lower than under the preceding 1984 Act, it has recently returned to the previous level.

²⁴⁸ See Lady Hale, 'Is it time for yet another Mental Health Act?' Speech to the Royal College of Psychiatrists Annual Conference, Birmingham on 24 June 2018. See also George Szmukler, 'Men in White Coats: Treatment under Coercion' (Oxford University Press, 2017).

Ultimately, given the difficulty of bringing two complicated pieces of legislation together, and the amount of time fusion legislation would require (experience in Northern Ireland tells us that at best this would take a decade, and probably longer), we have decided not to recommend the Government does this now. Instead we think that the immediate challenge is to bring both the MHA and the MCA 'up to date'. Essential reforms of both the MHA and MCA are needed now whatever the outcome of the 'fusion' debate.

More importantly, we think that there are five 'confidence tests' that would need to be met, before fusion is started. If these tests are met in the future, we think that the Law Commission should be asked to draft entirely new legislation with input from disabled people.

Test one – the views of service users

In line with the CRPD's requirement to involve service users fully in the decisions that affect their lives, we think that a key confidence test is whether fusion has sufficient support from service users. During our engagement processes we heard a number of service users outlining a key concern about a capacity-based mental health system, or full fusion. We heard examples of people in distress being told that nothing could be done because "you have capacity, and it's your choice what you do." The reasons for this may sometimes be understandable,²⁴⁹ and may represent system or training issues which could be addressed. However, service users will have to decide that being able to make their own decisions about admission is worth the risk of being refused treatment, or being left to do something that is harmful to themselves or others. At the moment we are not convinced that most service users would think this way.

²⁴⁹ For instance, this may be a reaction from overstretched staff (these examples often came from crisis services or A&E) with a very limited or non-existent choice of alternative services.

Test two – the Impact in Northern Ireland

The second confidence test should be an assessment of impact of the Northern Ireland legislation when it is implemented. We think it will be important to understand three key aspects:

1. Whether their legislation leads to an increase in formal detention (even though this would be via a capacity/best interests framework):
2. How the Northern Ireland version of fusion legislation works in the criminal justice context;
3. Any evidence of an increase in suicide; and
4. The impact on those with learning disability/autism, in particular regarding their length of stay in hospital facilities.

Test three – whether the assessment of capacity is reliable enough to provide the sole basis for care and treatment

The third confidence test is whether an assessment of decision-making capacity can bear the weight that fusion law would place upon it. The following are needed to help determine if this is the case:

1. A better understanding of how capacity is currently used within the MHA. If our recommendations are implemented, we will get a much better picture of this in practice for both admission and treatment;
2. Action to prevent misuse of mental capacity. We do not agree with the Committee on the Rights of Persons with Disabilities that mental capacity is simply an invalid concept in the context of delivering care and treatment²⁵⁰ – in part because we cannot see any acceptable alternative. But we do agree an assessment of someone's capacity can be misused. That risk might be increased if full fusion were introduced. Implementation of our other recommendations which introduce capacity elements into the MHA, (for instance in relation to Advance Choice Documents) will

²⁵⁰ See further Annex entitled 'Treatment of involuntary placement/treatment and mental capacity by international human rights bodies'

already require measures to be taken to secure against this risk, but it will be important to evaluate the impact of these measures before moving any further;

3. Embedding of decision-making assessments in the cultures of the professionals involved, supported by infrastructure and training. There also needs to be an agreed way to resolve disputes when professionals don't agree on capacity. Again, we would expect this will develop if our recommendations are implemented; and
4. Research into how the legal test of decision-making capacity in the MCA can be translated into practice. This should include:
 - the concept of “using and weighing;”
 - the relationship with clinical concepts such as “insight;”
 - the practical implications of the legal requirement for an “impairment or disturbance in the functioning of their mind or brain” to be the direct cause for someone’s inability to make a decision. This research should be multi-disciplinary, shaped by service users, and firmly linked to both practice and policy-makers.²⁵¹

Test four – that associated processes are adapted to support the change

The fourth confidence test is that key processes that would be needed to support fusion law are resilient enough. This includes ‘supported decision-making’ and ‘enabling legal capacity.’ The following are important building blocks which require development:

5. Support to find out a person’s level of decision-making ability (e.g. communication, education), and to shift their decision-making inability to decision-making ability. For example, this might mean removing things that compromise their ability (e.g. other people, or the environment that they are in), or delivering specific interventions to help them;

²⁵¹ An example of such research is that being carried out by the Wellcome-funded Mental Health and Justice Project, which supported our review through holding two policy labs in conjunction with the King’s Policy Institute, leading to a report published in May 2018 on the future of the Mental Health Act (<https://www.kcl.ac.uk/sspp/policy-institute/publications/the-future-of-the-mental-health-act.pdf>).

6. Support to help participation in best interests decision-making such as advocacy, and expression of and respect for wishes and preferences; and
7. Robust advance decision-making mechanisms capable of working in a ‘fused’ system. Work will also be required to set out how advance decision-making fits with the requirements of the CRPD.

Test five – public interest

The final confidence test is whether fusion law can take proper account of what is in the public interest, particularly when it comes to the risk of harm to others. We have considerable reservations as to whether the concept of ‘best interests’ can work in this respect. We think at this stage that necessity and proportionality are likely to be more appropriate assessments.

Conclusions

Even if fusion currently looks like the most promising direction for future travel, things may well have moved on by the time our five tests can be delivered. Some jurisdictions may choose to ‘turn the clock back’, perhaps by ‘writing off’ the ability of those with disabilities to make decisions. We could not tolerate that. On the other side of the spectrum, many countries are reforming both mental health and mental capacity legislation to be more in line with by CRPD and the work of the Committee on the Rights of Persons with Disabilities. How this works in practice and, more importantly, what difference it will make for service users and patients²⁵², remains an open question. We hope that Government will keep an open mind to the potential that we may, in due course, find new societally and morally acceptable ways in which to balance the multiple, competing, rights and interests of the people in our care.

²⁵² For instance, legislation that asserts full legal capacity for all is, in practice, unlikely to make any substantive difference if it sits in a legal system that contains provision for the delivery of treatment in an emergency, especially if the concept of ‘emergency’ is broadly defined.

CONCLUSION

This report and our recommendations respond directly to the objectives set by the Prime Minister last year. We hope that readers of this report will find that we are making a real attempt to change things for the better. Given the range of differing views, and the complexity of both the law and the operational landscape, this has not been an easy task, and it is not likely that we have managed to give everybody precisely what they had hoped for. We do hope that everyone will find something that will make a meaningful and positive change for them.

We believe our recommendations will help make the Mental Health Act support our modern expectations of how people, particularly disabled people and people from ethnic minority communities, should be cared for. If implemented, patients and service users should experience improved choice, less coercion and restriction of their liberties, care that is more consistently respectful, and meets their individual needs.

The Review asks the Government to commit to accepting these proposals, to making legislative changes once parliamentary time allows, and looks forward to its formal response.

AFTERWORD - REVIEW CHAIR

PERSONAL REFLECTIONS

The test when seeking a chair for an independent review is to find someone who is not an expert in the topic. Anyone with too much knowledge would not be in a state of equipoise – in other words would already know what should be done. Not me. Once I completed my training, my clinical work has been in general hospital psychiatry, and my academic career has first been around unexplained symptoms and syndromes, and more recently our Armed Forces. Neither area brought me into contact with the issues or people at the heart of this Review.

This started to change four years ago when I became President of our Royal College, but even this did not compare to the transformation of the last 18 months – perhaps the most intense period of Continuous Professional Development one could devise.

Some of it has been tough. Listening to some of the stories and experiences of the patients and service users²⁵³ has been a salutary and chastening experience. At times all I could say was that I am sorry you had those experiences, and I hope that this Review will ensure this becomes a thing of the past.

But I have also had numerous positive experiences, and met an extraordinary range of people, professionals and service users alike.

And in the end I am not despairing, but hopeful. I recall visiting Look Ahead, a social housing organisation providing specialist support and care services for people with the most complex and severe of mental illnesses. I learnt about how they help those who have spent long periods of time in hospitals move towards more independent living, and the impact of austerity on some of the most vulnerable. I saw the close working relationship with their local Trust, and the unsolicited praise for several named psychiatrists for the support they give.

²⁵³ As stated in my Foreword, I acknowledge the differences of opinion about the correct nomenclature here. I have used patients as in the word "inpatients", but service users for the wider context

As I went to numerous professional gatherings of social workers and AMHPs I experienced their enthusiasm for their role, which convinced me that we should not touch the critical balance between the social and medical perspectives, or more accurately between health and social care, enshrined in the 1959 Act, but should strengthen those links. Like psychiatry, the police sometimes got a bad press from patients and carers, but I also heard numerous stories of individual acts of compassion and kindness, and met officers from the lowest to the highest rank committed to innovation and change. Reconnecting with colleagues old and new in my profession was a joy. Likewise, I have always had a sneaking admiration for the skills and wisdom of the judiciary, but a year of close interaction with those involved in mental health has shown me that this admiration is based on fact.

And then there were my three splendid Vice Chairs, and the twelve experts, professionals and experts by experience, who were persuaded like me, to give a day a week of their time to the Review for the duration. Yes that turned out to be the understatement of the year, but none of you complained, and all gave far more than anyone could have expected.

And another group with whom I interacted on a daily, and often nightly, basis, are the civil servants who made the Review possible, and provided me with all the support I needed. Their commitment to the cause of improving the experience of service users in our mental health system was remarkable. I enjoyed Gus O' Donnell's robust defence of the civil service and its values – and now I experienced it at close hand. When we say we have the best civil servants in the world we are speaking no more than the truth.

And there are other reasons for optimism. A revitalisation of community services that provide alternatives to detention for those with severe mental illness, and a new offer for those with learning disabilities and autism, are both very much on the cards. I am no Mystic Meg, but I expect some real change here, essential if we are to achieve the goals we have set ourselves. Legislation can only achieve so much - a reduction in compulsory admissions requires sustained investment in crisis services, and other innovative, often locally led, alternatives to detention. And I am far from alone in recognising that when compulsory detention is still necessary, it should provide both sanctuary and an environment conducive to improvement. I cannot over emphasise that the core of our recommendations must be taken alongside the forthcoming NHS Long Term Plan – improved crisis and community services are essential if our recommendations are to be effective.

I also can see that the enthusiasm felt by a younger generation for all things connected with mental health is starting to be reflected in career choices. Clinical psychology is oversubscribed, recruitment to psychiatry has started to pick up. There is a long way to go, especially for nursing and social work, without which our services will simply collapse. But a start has been made.

And finally, there are the service users. Largely unheard at the start of my career, now they are a major force for change and improvement. When I started the Review, I promised that service users would be at the heart of everything we would do. It's a cliché, but sometimes clichés can be true. The commitment of those who have experienced detention has been astonishing, and if some stories made uncomfortable hearing, this bred not bitterness, but instead a powerful desire for improvement. Service users took part in every one of the expert groups we created, and were an integral part of all decision making. There is hardly a recommendation that has not been either started by, or shaped by, their input. I am not a sentimental person, but I felt my eyes well up at the last meeting of our core service user and carer group as we discussed for the final time the shape of what you are about to read. I sincerely hope we have done them justice.

ANNEXES

Annex A: Treatment choices

1. Our view is that wherever possible we should look for parity between mental and physical health. These changes will bring the position for treatment choices in mental health closer to that for physical health. But as we say earlier in our report, there are differences between mental health and physical health; that is why there is no equivalent to the Mental Health Act for physical health and why, though we have made it more difficult for clinicians to administer treatments patients have refused, we are not proposing that patients under the Act should be able to refuse treatment altogether.
2. This Annex deals with our recommendations on treatment choices relating particularly to drugs and invasive procedures. These will only be effective if our recommendations on shared decision-making and advance choices are also put in place. They should be seen in the context of the cultural change focussed on respect, dignity and the individual that our recommendations are intended to bring about. The chapter on Choice and Autonomy provides more details on Advance Choice Documents (ACD), and the use of shared decision-making in care planning
3. The tables below summarise the proposed approach to treatment choices covered in this Annex. The proposed framework set out in this Annex applies to all patients being treated under the Act whether in a hospital or in the community and those subject to Part 3 of the Act.
4. We are proposing:
 - a. **Category 1 - Treatments which may only be given with consent.**

These treatments could not be given unless a patient has consented to it, 2 independently appointed individuals have certified that the patient has capacity to consent and, in addition, a SOAD has certified that the individual has capacity to consent and treatment is clinically appropriate.

Advance consents to treatment will not be allowed for this category and they cannot be given in an emergency.

The Review recommends that Government should consult on which treatments should be in this category. These should be specified in regulations and could

include treatments like neuro-surgery for mental disorder and Deep Brain Stimulation.

b. Category 2 – Treatment refusals made with capacity or in an ACD can only be overruled with a judge

These treatments cannot be given to a person with capacity who has refused them (including through an authenticated ACD) except with the prior approval of a judge where there is a threat to life or to prevent serious deterioration in condition. Any application to court to seek such approval must be supported by two medical opinions.

If an individual does not have capacity, then as long as they have not made an authenticated ACD to refuse it, the treatment may be given following a best interests assessment and certification by a SOAD that the treatment is clinically appropriate. Where the treatment is immediately necessary to prevent death or, a serious deterioration in condition SOAD certification will not be required but in these cases the CQC must be informed when it has been used and the reasons for doing so. This will enable scrutiny of the decision.

Advance consent to treatment would not be allowed for this category.

Government should consult on which treatments should be in this category. These should be specified in regulations and could include treatments like ECT.

c. Category 3 – All other treatments.

We recommend that clinicians should have regard to any preferences expressed by the patient for treatment in this category and should adhere to those preferences as far as possible, where the treatment is clinically appropriate. Treatments in this category can be administered in the following circumstances:

- If a patient with capacity consents
- If a patient does not have capacity and has not refused the treatment as part of an authenticated ACD, following a best interests assessment which should include consideration of any unauthenticated ACDs.
- Where treatment is given to a patient without capacity on this basis there should be a review of the treatment by a SOAD. This review should happen earlier than the current 3 months and we think that Government should work with CQC and other interested parties to agree a framework for these reviews,

including a process for agreeing when a review should take place and the basis for further reviews.

In addition, where a patient with capacity is objecting to treatment or has refused it as part of an authenticated ACD (see Choice and Autonomy chapter), the treatment may be given:

- If there is no other clinically appropriate treatment available more acceptable to the patient, the treatment is clinically appropriate and given in the smallest effective dose, and these conditions are certified by a SOAD as satisfied.
- Advance SOAD review will not be necessary to administer treatment where:

the treatment is immediately necessary to prevent death, prevent serious deterioration in condition, to prevent the patient from behaving violently or being a danger to themselves or others, or, where the refusal is part of an ACD, to alleviate serious suffering..

Recording Choices

5. We think it is important that clinicians record the treatment decisions they make., This will enable effective review and monitoring of their choices. As a minimum we believe the following should be recorded:

- Discussions with patients, nominated persons (NP), advocates on treatment choices and a clear statement of any refusals, consent or preferences
- Record of advance choices and how these have been taken into account
- Where a patient does not have capacity and has not made advance choices, a record of the conclusions of the best interests assessment, including any stated wishes of the patient
- Reasons for why patient preferences/refusals have not been followed (e.g. not clinically appropriate)
- Safeguards used (e.g. that SOADs have been asked to undertake review, patient has been certified competent)

- In most cases our view is that these should be included in the care plan but where refusals of treatment (made either with capacity at the time, or contained in an authenticated ACD) have been overridden we think that the providers lead on MHA administration should hold the record. This will enable providers, commissioners, regulators and SOADs to review treatment decisions and identify any issues with hospitals respecting the choices of patients.

Challenge

6. As well as providing a framework which ensures patients' views and wishes are taken into account in treatment decisions, we are recommending new rights for patients to question and appeal treatment decisions made about them.
7. We want patients and, where they do not have capacity, their NP or advocate to be able to request a SOAD review from the date at which their care and treatment plan is finalised or 14 days whichever is the sooner and, following review by a SOAD, we want them to be able challenge specific treatment decisions at the Tribunal. More details of our recommendations on this can be found in the Choice and Autonomy chapter.

Immediately Necessary Treatment

8. The Review also recommends that additional provisions are introduced to ensure that the period during which a treatment is administered against an objection on the grounds that it is immediately necessary is restricted to the shortest possible time, and that there is a limit to the number of treatments that may be administered during that period.

Attorneys and Deputies

9. We recommend that Attorneys and Deputies appointed under the MCA should be able to act on behalf of patients who don't have capacity. Their treatment choices should be treated in the same way as treatment choices expressed by a patient with capacity. We think there should be two exceptions to this. First, we do not believe that attorneys or deputies should be able to agree to Category 1 treatments, as these treatments can only ever be given on the basis of the consent of the patient. Second, we believe that advance choices should be given priority over decisions of the attorney/deputy unless an attorney was appointed after the advance choice document was made.

Children under the age of 18

10. For children under the age of 18, we believe that, as far as possible, the same approach should apply. As discussed in the Children and Young People chapter, we think that capacity test set out in the MCA should apply to those aged 16 and above to determine whether they have the ability to make relevant decisions. Where a 16/17 year old has that capacity, then, with one exception (see below), they should be treated as if they were an adult for these purposes. The same should also apply to those under 16 who are competent to make the relevant decisions.
11. For 16/17 year olds who lack capacity, or those who are under 16 and are not competent to make decisions, we recommend that treatment decisions should be made following a best interests assessment. We also think that this could provide a framework within which the views of parents and carers could be considered.
12. The exception to the general position set out above is in relation to advance choices to refuse treatment (whether authenticated or otherwise). As we say above the Review's aim in this is to bring the provisions in mental health closer to those that prevail in physical health. Children under 18 are not able to make advance decisions to refuse treatment under the MCA, and our view is that we should adopt this approach for the Mental Health Act. However, if a child or young person did express their choices in advance we would expect they would be taken into account as part of the best interests assessment.

Role and Impact on SOADs

13. As they will be acting as the gateway to tribunal, SOADs will need to look at specific prescriptions rather than generic families of drugs and we would also expect their review of a treatment to consider a patient's diagnosis and alternative treatments including psychological therapies. We understand that these are already consistent with the SOAD role and therefore do not expect that this will require a significant change in practice.
14. As we set out in the body of the report we understand that our recommendations for SOADs are likely to result in a significant increase in their use which will in turn impact on resources. See the Choice and Autonomy chapter for our consideration of this.

Ensuring Current Safeguards are not lost

15. Our intention throughout is to improve safeguards and make it harder to override the choices of people subject to the Act. Where we are broadly adopting existing provisions the same requirements will apply (e.g. the requirements to certify capacity for section 57 will apply to Category 1 and the SOAD certification for Category 2 must be on the same basis as currently for ECT). These are in addition to the new safeguards we are recommending.

Table 1– Taking a Patient's View into Account in Treatment Decisions - Where the patient has capacity at time of decision

| Category | Patient's Choice | When treatment can be given |
|------------|------------------|---|
| Category 1 | Consent | Can only be given if: A SOAD certifies that the patient has capacity and the treatment is appropriate and 2 other independently appointed individuals certify that the patient has capacity |
| Category 1 | Refusals | Treatment cannot be given, even in cases of emergency |
| Category 2 | Consent | Yes if: Clinician confirms that patient has capacity to consent |
| Category 2 | Refusals | Treatment cannot be given except with the prior approval of a judge where treatment is immediately necessary to prevent death or to prevent serious deterioration. The application to the court must be accompanied by two medical opinions. |
| Category 3 | Consent | Should be discussed as part of care and treatment planning Clinicians should seek to follow patient preferences where possible and clinically appropriate. |
| Category 3 | Refusals | Treatment can only be given where EITHER SOAD certifies that: Treatments acceptable to the patient are not available or are not clinically appropriate Treatment is clinically appropriate and It is given in the lowest dose and for the shortest period necessary to be effective OR Where it is immediately necessary to save life, to prevent a serious deterioration in condition, or to prevent violence or damage to self and others. |

Table 2– Taking a Patient's View into Account in Treatment Decisions - Where the patient has authenticated Advance Choice but currently lacks capacity to consent to or refuse treatment

| Category | Patient's Choice | When treatment can be given |
|------------|------------------|---|
| Category 1 | Consent | Consent not valid in advance |
| Category 1 | Refusals | Treatment cannot be given |
| Category 2 | Consent | Consent not valid in advance |
| Category 2 | Refusals | Treatment cannot be given except with the prior approval of a judge where treatment is immediately necessary to prevent death or to prevent serious deterioration. The application to the court must be accompanied by two medical opinions. |
| Category 3 | Consent | Clinicians should seek to follow patient preferences where possible and clinically appropriate. |
| Category 3 | Refusals | <p>Treatment can only be given where</p> <p>EITHER</p> <p>SOAD certifies that:</p> <p>Treatments acceptable to the patient are not available or are not clinically appropriate Treatment is clinically appropriate and It is given in the lowest dose and for the shortest period necessary to be effective</p> <p>OR</p> <p>Where it is immediately necessary to save life, to prevent a serious deterioration in condition, to alleviate serious suffering or to prevent violence or damage to self and others.</p> |

Table 3– Taking a Patient's View into Account in Treatment Decisions - Where the patient does not have capacity and there is no authenticated Advance Choice Document

| Category | When treatment can be given |
|------------|--|
| Category 1 | Treatment cannot be given without capacitous consent given at the time |
| Category 2 | <p>Treatment can only be given following best interests assessment and SOAD certification</p> <p>OR</p> <p>Where it is immediately necessary to save life or prevent a serious deterioration in condition. CQC to be informed and provided with reasons for use.</p> |
| Category 3 | Decision to use must be made following best interests assessment which should consider patient’s previously expressed views and wishes. SOAD review of treatment required in time frame to be considered by Government, but shorter than current 3 month period. |

Annex B: Treatment of involuntary placement/treatment and mental capacity by international and regional human rights bodies

Introduction

1. The following provides some (non-exhaustive) examples of the different approaches currently taken by different international human rights bodies/actors to involuntary placement and treatment as well as the concept of mental capacity²⁵⁴. All of these areas are subject to sustained discussion at the international level and interpretation by different courts, such that this annex represents a snapshot of the position as at November 2018. As set out in the body of the report, the different legal approaches to the steps that should be taken in hard cases can also mask substantial areas of common ground, above all as to what should be done to ensure that those steps are not, in fact, required. Nonetheless, there remain substantially different interpretations (at international and regional level) of human rights obligations in this context.

Involuntary placement

2. Article 14(1)(b) CRPD makes clear that “the existence of a disability shall in no case justify a deprivation of liberty.” However, the UN Human Rights Committee (the treaty body for the International Covenant on Civil and Political Rights, which includes its own right to liberty) and the Committee on the Rights of Persons with Disabilities have given differing interpretations of Article 14(1)(b).

²⁵⁴ The differing views of relevant UN bodies as to involuntary detention and treatment are usefully summarised in a detailed document prepared by Dr Sándor Gurbai and Prof Wayne Martin of the Essex Autonomy Project from which this, in part, draws: <http://autonomy.essex.ac.uk/resources/eapunsurvey/>. See also by way of overview articles Fennell, P.W.H. and Khaliq, U., ‘Conflicting or complementary obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English law,’ *European Human Rights Law Review*, 2011:6:662-674 and Bartlett, P., ‘The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law,’ *Modern Law Review*, 2012:75:752–778.

3. Both Committees agree that deprivation of liberty on the basis of disability alone is unlawful²⁵⁵. However, the two Committees differ as to whether it is ever permissible to deprive a person of their liberty to secure against risks to them or other people said to arise from their mental health condition (i.e. their disability). The Committee on the Rights of Persons with Disabilities takes the view that “[t]he involuntary detention of persons with disabilities based on risk or dangerousness, alleged need of care or treatment or other reasons tied to impairment or health diagnosis is contrary to the right to liberty, and amounts to arbitrary deprivation of liberty.”²⁵⁶ This view is shared by others within the UN system, for instance the Office of the High Commissioner for Human Rights²⁵⁷, and the Special Rapporteur on the Rights of Persons with Disabilities²⁵⁸.

4. The UN Human Rights Committee, conversely, takes the view – which it sees as supported by Article 14(1)(b) CRPD – that “[t]he existence of a disability shall not in itself justify a deprivation of liberty but rather any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others,” and further that “[f]orced measures must be applied only as a measure of last resort and for the shortest appropriate period of time, and must be accompanied by adequate procedural and substantive safeguards established by law.”²⁵⁹ A similar view has recently been taken by the UN Human Rights Council Working Group on Arbitrary Detention (‘WGAD’)²⁶⁰.

5. The lack of consensus at the UN level in relation to involuntary care and treatment was described in 2017 as an “impasse” by the UN Special Rapporteur in 2017 on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health²⁶¹. It is echoed at Council of Europe level, which is particularly relevant for the Review given the fact that Council bodies (including the

²⁵⁵ UN Human Rights Committee: General Comment No. 35 (2014), on Article 9 - Liberty and security of person, para 19; UN Committee on the Rights of Persons with Disabilities, 2015: “Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities.” para 6.

²⁵⁶ UN Committee on the Rights of Persons with Disabilities, 2015: “Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities.” para 13.

²⁵⁷ Office of the United Nations High Commissioner for Human Rights, 2009: Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities. A/HRC/10/48, para 48.

²⁵⁸ See her report of 12 December 2017 (A/HRC/37/56) at para 52.

²⁵⁹ UN Human Rights Committee: General Comment No. 35 (2014), on Article 9 - Liberty and security of person, para 19.

²⁶⁰ In the context of a complaint against Japan (Opinion No. 8/2018):

http://www.ohchr.org/Documents/Issues/Detention/Opinions/Session81/A_HRC_WGAD_2018_8.pdf,

²⁶¹ Dainius Pūras, “Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (2017) A/HRC/35/21, para 33

European Court of Human Rights ('ECtHR') are the treaty bodies for the ECHR, which is binding on public bodies – including the courts – in England & Wales:

- The Council of Europe's former Commissioner for Human Rights, Nils Muižnieks, has expressly endorsed the position of the Committee on the Rights of Persons with Disabilities²⁶²;
- Conversely, the ECtHR has continued to hold that deprivation of liberty is lawful where it is a necessary and proportionate response to secure a person of unsound mind against risk to self or others. It has, significantly, done so having expressly considered the position of the Committee on the Rights of Persons with Disabilities set out above²⁶³. Further, case-law of the ECtHR could also be read not merely as permitting deprivation of liberty on this basis, but also requiring it where it is necessary to secure the right to life of a vulnerable individual²⁶⁴. The logic of the decision of the United Kingdom Supreme Court in *Rabone v Pennine Care NHS Trust* [2012] UKSC 2 was also to the effect that Article 2 of the ECHR imposed an obligation upon the relevant authorities to deprive Melanie Rabone of her liberty (in the psychiatric hospital where she was an informal patient) rather than allowing her to return home, where she took her own life.

Involuntary treatment

6. At the UN level, the Committee on the Rights of Persons with Disabilities takes the view that administering medical treatment absent free and informed consent is always unlawful as contrary to Articles 12 and 25 CRPD²⁶⁵. This view is shared by other UN actors²⁶⁶, but not all. For instance, UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment not only considers that involuntary treatment is lawful in circumstances where (essentially) the individual lacks capacity to make decisions as to treatment as “a last resort to avoid irreparable damage to the life, integrity or health of the person concerned,” but

²⁶² <https://www.coe.int/en/web/commissioner/-/respecting-the-human-rights-of-persons-with-psycho-social-and-intellectual-disabilities-an-obligation-not-yet-fully-understood?inheritRedirect=true&redirect=%2Fen%2Fweb%2Fcommissioner%2Fthematic-work%2Fpersons-with-disabilities> (August 2017).

²⁶³ *N v Romania* (Application No. 59152/08), decision of 28 November 2017, at para 159.

²⁶⁴ See *Stanev v Bulgaria* (Application No. 36760/06), decision of 17 January 2012 at para 128.

²⁶⁵ UN Committee on the Rights of Persons with Disabilities, 2014: “General Comment No. 1 on Article 12: Equal recognition before the law.” CRPD/C/GC/1, para 41.

²⁶⁶ See the views summarised in the July 2018 Report of the United Nations High Commissioner for Human Rights on Mental Health and Human Rights: A/HRC/39/36

indeed that the withholding of treatment in such circumstances could be a human rights violation, since failure to provide treatment could constitute inappropriate practice, amount to a form of cruel, inhuman or degrading treatment or punishment, and constitute a form of discrimination²⁶⁷.

7. The Council of Europe's Commissioner for Human Rights appears to adopt a similar position to that of the CRPD Committee vis-à-vis involuntary treatment²⁶⁸. The ECtHR has not, however, outlawed forced treatment for mental disorder (including of those with decision-making capacity). Indeed, it has held that the positive duty on states to protect the right to life under Article 2 ECHR "obliges the national authorities to prevent an individual from taking his or her own life if the decision has not been taken freely and with full understanding of what is involved."²⁶⁹ It has also found a violation of Article 2 ECHR where doctors took the refusal of an individual showing symptoms of a mental disorder to consent to potentially life-saving physical treatment at face value "without putting in question [the man's] capacity to take rational decisions concerning his treatment,"²⁷⁰ and the man then subsequently died. The ECtHR has, though, increasingly recognised that providing non-consensual treatment constitutes a serious interference with the individual's right to autonomy, requiring suitably strict procedural safeguards: see, for instance, *X v Finland* [2012] ECHR 1371.

8. For completeness, it should be noted that the German Federal Constitutional Court of 26 July 2016 (1 BvL 8/15) has also held that, even taking into account the views of the CRPD Committee, there are no good reasons under the text and spirit of CRPD to conclude that the CRPD is opposed to compulsory medical treatment where this is constitutionally required under strictly regulated circumstances.²⁷¹

²⁶⁷ UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 2016: "Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalized and treated medically without informed consent". CAT/OP/27/2, para 15.

²⁶⁸ See the comment noted above.

²⁶⁹ *Haas v. Switzerland* [2011] ECHR 2422, para 54. See also *Arskaya v Ukraine* [2013] ECHR 1235.

²⁷⁰ *Arskaya v Ukraine* [2013] ECHR 1235 at para 87.

²⁷¹ This decision is discussed at <http://www.39essex.com/content/wp-content/uploads/2016/11/MC-Newsletter-November-2016-Capacity-outside-the-Court-of-Protection.pdf>

Mental capacity, best interests decision-making and advance decisions

9. The Committee on the Rights of Persons with Disabilities considers that regimes such as the MCA 2005 are incompatible with obligations imposed by Article 12 CRPD (the right to equal recognition before the law)²⁷².

10. First, the Committee challenges the validity of linking mental capacity to legal capacity, the capacity, in particular, to make decisions regarded as having legal effect. The Committee asserts, in particular, that mental capacity is not “as commonly presented, an objective, scientific and naturally occurring phenomenon. Mental capacity is contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity.”²⁷³

11. Second, the Committee considers that substituted decision-making²⁷⁴, such as provided for in the MCA 2005, is impermissible. Rather, as set out in General Comment 1 (in particular), the Committee considers that only supported decision-making is acceptable. It is important to understand that the Committee’s interpretation of this concept includes, but goes further than, the principle in s.1(3) MCA that a person is not to be considered to lack capacity to take a decision unless all practicable steps to support them to do have been taken without success. The Committee does not accept, in essence, that it is ever permissible to conclude that a person lacks capacity to take a decision such that another person may take it on their behalf; rather the person must always be given the support necessary to express their will and preferences, which should dictate the outcome of the decision made. In extremis, the Committee consider, it is acceptable to proceed on the best interpretation of the person’s will and preferences; the Committee reject, however, any approach which enables the decision-maker to proceed on what is believed to

²⁷² Hence its recommendations in the Concluding Observations on the UK set out in the main body of this report.

²⁷³ UN Committee on the Rights of Persons with Disabilities, 2014: “General Comment No. 1 on Article 12: Equal recognition before the law.” CRPD/C/GC/1, para 14.

²⁷⁴ Defined as a situation where (i) legal capacity is removed from a person, even if this is in respect of a single decision; (ii) a substitute decision-maker can be appointed by someone other than the person concerned, and this can be done against his or her will; or (iii) any decision made by a substitute decision-maker is based on what is believed to be in the objective “best interests” of the person concerned, as opposed to being based on the person’s own will and preferences UN Committee on the Rights of Persons with Disabilities, 2014: “General Comment No. 1 on Article 12: Equal recognition before the law.” CRPD/C/GC/1, para 27.

be in the best interests of the person concerned, as opposed to the person's will and preferences.

12. It should be noted that on this interpretation of Article 12 CRPD, legislation which 'fused' mental health and mental capacity law (such as the Mental Capacity Act (Northern Ireland) 2016) would be incompatible with the CRPD²⁷⁵, as it would still proceed on the basis of a differential approach in law based upon whether the person had or lacked decision-making capacity.

13. The CRPD Committee encourages advance decision-making as an important form of support, "whereby [the person] can state their will and preferences which should be followed at a time when they may not be in a position to communicate their wishes to others." However, "[t]point at which an advance directive enters into force (and ceases to have effect) should be decided by the person and included in the text of the directive; it should not be based on an assessment that the person lacks mental capacity."²⁷⁶ On its face, the CRPD Committee's approach would therefore also rule out advance decision-making (including appointment of an attorney) in the form provided for in the MCA and (to a more limited extent at present) in the MHA²⁷⁷.

14. Outside the context of placement and treatment, the other UN bodies have not engaged with the concept of mental capacity in detail, although, as noted above, the UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment appears to accept the legitimacy of the concept of mental capacity.

²⁷⁵ The Committee on the Rights of Persons with Disabilities did not expressly comment upon this legislation in their Concluding Observations on the United Kingdom in 2017, but it had been drawn to their attention, and it is reasonable to assume that they intended to encompass it within their definition of (for them) illegitimate substituted decision-making.

²⁷⁶ UN Committee on the Rights of Persons with Disabilities, 2014: "General Comment No. 1 on Article 12: Equal recognition before the law." CRPD/C/GC/1, para 17.

²⁷⁷ See also the view of Zeid Ra'ad Al Hussein, UN High Commissioner for Human Rights that, even where advance directives of powers of attorney or in force, "Even when such instruments are in force, persons with psychosocial disabilities must always retain their right to modify their will and service providers should continue to seek their informed consent" (United Nations High Commissioner for Human Rights, 2017: Mental health and human rights. A/HRC/34/32), para 28.

15. There remains considerable debate as to the extent to which the CRPD Committee's interpretation of Article 12 goes beyond the obligations imposed by the Convention²⁷⁸. Most immediately, and importantly, for our purposes, the ECtHR has considered both Article 12 and the General Comment 1, in the context of interpreting Article 8 ECHR. The ECtHR sees Article 12 CRPD as imposing an obligation to require respect for the rights, will and preferences of the individual concerned, but does not see them automatically as determinative: see *AM-V v Finland* [2017] ECHR 273 (endorsing both a functional model of mental capacity analogous to that set down in the MCA 2005 and an approach similar to the best interests approach in the MCA 2005)²⁷⁹.

²⁷⁸ These issues are discussed in detail in the work of the Essex Autonomy Project on compliance of the mental capacity regimes in the United Kingdom with the CRPD: <https://autonomy.essex.ac.uk/subject/crpd/>.

²⁷⁹ Other courts, outside the Council of Europe, have interpreted the CRPD in this fashion, most recently the Supreme Court of Victoria in *PBU v Mental Health Tribunal and Melbourne Health; NJE v Mental Health and Bendigo Health* [2018] VSC 564.

Annex C: Summaries of commissioned evidence

Social and clinical correlates of involuntary psychiatric detention: a Systematic Review and Meta-Analysis

Summary for the Independent Review of the Mental Health Act

Authors: Euan Mackay, Susan Walker, Monica Leverton, Christian Dalton-Locke, Brynmor Lloyd-Evans, Sonia Johnson

Introduction

The number of people being involuntarily detained in psychiatric hospitals in the UK has been steadily growing over the last three decades, and this pattern can be seen in some other high income western countries.(1) The reasons for this increase remain unclear, but there is evidence to suggest that certain groups are subject to involuntary psychiatric hospitalization more frequently than others, including those from Black, Asian and Minority Ethnic (BAME) groups and those living in areas of high socioeconomic deprivation.(2) However, the research is conflicted and uncertainty remains about the factors which contribute to the risk of an involuntary admission, and the reasons why this might be.(3, 4) Understanding the risk factors for an involuntarily detention is imperative in order to reduce inequality, and implement appropriate measures to reduce the growing use of coercive psychiatric care. To date there has been no international systematic review or meta-analysis of the social and clinical determinants of involuntary psychiatric detention.

This review aims to update current knowledge regarding the risk factors for involuntary psychiatric admission in the UK and internationally.

Methods

Studies comparing characteristics or risks of involuntary vs voluntary inpatient admissions were included, as well as those comparing involuntary admissions to source populations. Studies of the association between ethnicity and involuntary care were excluded, as this has been covered in depth in our companion paper (Barnett et al. in press). Five databases (MEDLINE, PsycINFO, EMBASE, CENTRAL and CINAHL) were searched for relevant studies in English from 1983 to the present day. Three reviewers completed the study screening, and data extraction was done by four reviewers and included an assessment of study quality.

Members of the Lived Experience Working Group (LEWG) helped to identify the important clinical and social predictors to include in the search.

Meta-analyses were conducted where available data allowed: on gender, housing stability, employment status, relationship status, diagnosis, previous detention and previous inpatient admissions. Where meta-analysis was not feasible, narrative synthesis was performed.

Results

Sixty-nine international studies were included in the review, with the majority from Europe, and 7 from the UK.

Meta-analyses of pooled results demonstrated elevated risk of involuntary care for the following groups:

- Males
- People with a diagnosis of a psychotic disorder
- People with a diagnosis of bipolar disorder
- Those in receipt of social benefits
- People living with friends or relatives rather than their partner/children
- Non-home owners (i.e. those in rented accommodation compared to those in their own home)
- Single people
- People who were previously married/in long-term relationship (i.e. separated, divorced or widowed)
- People who have had a previous involuntarily detention

Those with mood disorders, anxiety disorders and personality disorder were significantly more likely to be admitted to hospital voluntarily.

In the narrative analysis, associations were found with involuntary admission and the following factors:

- Increased severity of psychotic symptoms, lack of insight, reduced psychosocial functioning, presence of aggression or agitation measured using a variety of tools (e.g. Brief Psychiatric Rating Scale) on admission
- Risk to others, including actual episodes of violence, perceived risk of violence and violent behaviour
- Absence of social support or care giver
- Police involvement in admission (strong association)
- Area level deprivation
- Limited availability of inpatient beds (weak association)
- History of criminal behaviour (weak association)

The clinical factors that were associated with a voluntary admission were symptoms of depression and anxiety on admission. Despite being a criteria for admission under the Mental Health Act in the UK and many other countries, risk to self, including suicidal ideation, behaviour and intent was associated with voluntary admissions. Use of outpatient services prior to admission, GP referral (or GP involvement in admission) and availability of less restrictive crisis care were also all associated with voluntary admissions. History of treatment compliance and education level were not found to be associated with the legal status of admission.

Discussion

Our study demonstrates that those without long term partners and those reliant on social benefits are subject to an increased risk of detention. This may reflect the protective role of social support, and the increased risk of severe mental illness for the most vulnerable people in society. Conversely, it may reflect isolation and marginalisation of those living with severe mental illnesses. Individuals with psychotic disorders or psychotic symptoms are at increased risk for detention. This may reflect clinical need, though it may be a gap in the provision of optimal alternative crisis care for people with psychoses. The involvement of police was a risk factor for detention, while involvement of the GP was a protective factor, highlighting the need to try to optimise early and non-coercive pathways to care for people with mental health problems. Social support and provision of services are important in ensuring the best treatment trajectories for individuals and may be key to addressing the increasing use of coercive care.

This systematic review identifies key social and clinical determinants of involuntary psychiatric detention through use of both meta-analyses and narrative syntheses. However, our ability to draw causal inferences into, or assess the cumulative risks of, the multifarious roots of involuntary care is limited by the existing literature base. Despite a wide selection of studies, due the reporting of group level characteristics over individual data, we cannot examine the interplay of various risk factors that can contribute to severe mental illness and in turn involuntary psychiatric detention. In many studies, socioeconomic factors were underreported and area or community deprivation was not described in sufficient detail to draw firm conclusions.

Full understanding of the equity of application of involuntary psychiatric detention would be supported by comprehensive routine data recording of the characteristics and circumstances of individuals with severe mental illness and those detained, alongside further research.

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A full report of this review has been submitted for publication in a peer-reviewed scientific journal.

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A qualitative meta-synthesis of patients' experiences of assessment and detention under mental health legislation

Summary for the Independent Review of the Mental Health Act

Authors: Syeda Ferhana Akther, Emma Molyneaux, Ruth Stuart, Sonia Johnson, Alan Simpson, Sian Oram

Introduction

Understanding patients' experiences of detention under mental health legislation is crucial for efforts to reform policy and practice. Two previous reviews [1, 2] have sought to synthesise evidence on patients' experience of involuntary admission, and have identified both negative and positive experiences. Seed et al., for example, described how patients' experiences of involuntary admission varied, with some experiencing a sense of sanctuary while others experienced trauma, fear, and a loss of their sense of independence and normality [2]. However, both reviews employed a limited search strategy, were restricted to studies published in English, and excluded papers focusing on the experiences of people with certain diagnoses, such as eating disorders, and detained in certain settings, such as forensic facilities. A more comprehensive and current review is therefore required.

This review aimed to synthesise qualitative evidence on patients' experiences of being formally assessed for involuntary admission and the subsequent experience of detention in a psychiatric hospital.

Method

Peer-reviewed studies were included if they

1. Examined patients' experiences of being formally assessed for involuntary admission, and/or being detained in hospital, including appeal and tribunal processes
2. Included participants over the age of 18
3. Reported on individual qualitative interviews or focus groups.

Studies were excluded if they used a mixed sample of both involuntarily and voluntarily detained patients with no separate analysis for involuntary patients. No restrictions were placed on study language or setting.

Five databases (Medline, PsycINFO, HMIC, Embase and the Social Science Citation Index database) were searched for relevant studies conducted since 1983, the year in which the current legislative framework for involuntary detention and treatment in England came into force. Study screening was conducted by one reviewer, with 10% of papers screened independently by a second reviewer. The CASP Qualitative Research Checklist was used to assess the quality of included studies.

Thematic synthesis was used to analyse and synthesise data and followed a four-stage process [3]: 1) line-by-line coding of two papers by four review authors; 2) identification of descriptive themes; 3) application of the thematic framework to the remaining manuscripts, adding new themes and collapsing others in an iterative process of coding and analysis, and 4) generation of analytical themes. The thematic framework was shared with the NIHR Mental Health Policy Research Unit's Lived Experience Working Group, and their comments and feedback were incorporated.

Results

56 papers were included in the review, with most conducted in the UK (31 studies), Sweden (9 studies), Australia (5 studies), Ireland (5 studies) and Norway (2 studies). One study was identified from each of Australia, Finland, Greece, Israel and the USA.

Five themes were identified: 1) information and involvement in care; 2) quality of the environment; 3) quality of relationships; 4) impact on self-worth; 5) emotional impact of detention. These themes were consistent across studies despite the different legislative systems of the countries in which studies were conducted. Patients' experiences of involuntary admission were profoundly affected by the quality and timeliness of information provision, the extent of involvement in treatment decisions, and the quality of their relationships with staff. The emotional impact of detention varied but patients often described fear and distress, as well as reduced self-worth and an increased sense of being stigmatised. These feelings were described in particular with relation to disempowerment during detention and coercive interventions. The negative impacts of involuntary psychiatric admission seemed to be reduced when patients received clear and individualised information and felt that staff were striving to form caring and collaborative relationships.

Discussion

Patients in several studies believed that their involuntary admission had kept them safe at a time when they could not recognise the severity of their illness, but negative experiences were very often described. The review highlighted a number of ways in which it might be possible to reduce negative impacts of detention.

Limitations

Studies provided detailed information on patients' experiences during involuntary admissions and on police involvement in admissions, but evidence was almost completely lacking on experiences of being assessed for detention in community or hospital settings. The process of synthesising findings across a large number of qualitative studies, conducted in different settings and using a variety of methods, invariably leads to the loss of nuance and simplification of findings. During analysis we were not able to analyse data separately by patient group, including whether experiences vary by sex, gender, ethnicity, or diagnosis, due to the limited extent to which primary studies considered these questions.

Implications for research and practice

There is a lack of research focusing specifically on the experiences of Black, Asian, and Minority Ethnic (BAME) patients who have been detained under mental health legislation, which should be addressed by future studies. This has been an important omission to date as BAME patients are more likely to experience involuntary psychiatric admissions. Our findings suggest a number of potential foci for interventions to improve experiences of involuntary care, for example better strategies to ensure the effective communication of important information, greater involvement of patients in decision making, and increased attention to improving staff-patient relationships. The selection, development, implementation and evaluation of strategies to improve these areas should utilise co-produced approaches involving patients, carers and clinicians.

Acknowledgement

This report is based on independent research commissioned and funded by the National Institute for Health Research Policy Research Programme, through the NIHR Mental Health Policy Research Unit. The views expressed are those of the author(s) and not necessarily those of the NHS, the National Institute for Health Research, the Department of Health and Social Care or its arm's length bodies, and other Government Departments.

A full report of this review has been submitted for publication in a peer-reviewed scientific journal.

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A qualitative meta-synthesis of carers' experiences of compulsory admission under mental health legislation

Summary for the Independent Review of the Mental Health Act

Authors: Ruth Stuart, Syeda Akther, Karen Machin, Karen Persaud, Prof Alan Simpson, Prof Sonia Johnson, Dr Sian Oram

Introduction

Carers (family and friends who provide day-to-day support) are key providers of care and support to mental health service users and mental health policies consistently mandate carer involvement in treatment and care. However, several studies have found that many carers feel marginalised or excluded by mental health services. The detention of a patient under mental health legislation is likely to have significant impacts on carers as well as on patients, and may pose particular challenges for carer involvement. This review therefore aimed to synthesise qualitative evidence on carers' experiences of the assessment and detention of patients under mental health legislation.

Methods

Our systematic review included electronic searches of five bibliographic databases, supplemented by reference list screening and citation tracking. Five databases (Medline, PsycINFO, HMIC, Embase and the Social Science Citation Index database) were searched for relevant studies conducted since 1983, the year in which the current legislative framework for involuntary detention and treatment in England came into force.

Peer reviewed studies were included if they (1) reported on carer experiences of assessment or detention under mental health legislation anywhere in the world; (2) reported on carers of patients aged 18 years or older; (3) collected data using qualitative methods. No restrictions were placed on study language or setting.

Study screening was conducted by one reviewer, with 10% of papers screened independently by a second reviewer. Two reviewers independently used the CASP Qualitative Research Checklist to assess the quality of included studies.

Thematic synthesis was used to analyse and synthesise data (Thomas & Harden 2008) and followed a four-stage process, as follows: 1) four reviewers (including one member of the NIHR Mental Health Policy Research Unit's Lived Experience Working Group) independently conducted line-by-line coding of 2 papers; 2) four reviewers worked collaboratively with the coded papers to identify descriptive themes, which were shared with the NIHR Mental Health Policy Research Unit's Lived Experience Working Group for their comment and feedback; 3) one reviewer applied the thematic framework to remaining manuscripts, iteratively developing new codes and/or merging codes as appropriate, and 4) two reviewers collaborated to generate analytical themes.

Results

Twenty-three papers met our criteria for inclusion in the review. Twelve reported on studies conducted in the UK (6 in England, 1 in Wales, 2 in Northern Ireland, 1 in Scotland, and 2 not specified), with the remaining studies conducted elsewhere in Europe (Germany, Greece, Norway, the Republic of Ireland), Canada, the USA, and Australia. Study samples ranged in size from 3 to 103 participants, with 17 of the 23 included papers reporting on fewer than 20 participants. Themes related to the emotional impact of detention; the impact of detention on carers' relationships with those they cared for; the extent to which carers felt involved in decision-making and the provision of care; the availability of support for carers; and the quality of care provided to patients prior to and during detention. Carers often described conflicting feelings of relief, distress and guilt about the compulsory admission coupled with concerns about how the patient will cope and respond. Carers also spoke about the need for timely and accessible information, for supportive and trusting relationships with mental health professionals, and for meaningful involvement as partners in care.

Discussion

The themes of this review were strikingly consistent across time and setting, and echoed findings from earlier guidelines and reports (NICE 2011, The Carers Trust 2013, Department of Health 2015). These included the importance of timely and accessible information, of supportive and trusting relationships with mental health professionals, and of involvement as partners in care

Limitations

The scope of the review did not include the experiences of carers of child and adolescent patients, carers' experiences of community treatment orders (CTOs), or the perspectives of mental health and other professionals involved in the assessment and detention of patients under mental health legislation. Limited evidence was available regarding the experiences of carers of patients detained in secure settings, and it was not possible to analyse whether experiences differ by sex, gender, ethnicity, or patient diagnosis, due to the limited extent to which primary studies considered these questions, or by country or period, due to the limited time and resources available. The process of synthesising findings across multiple qualitative studies, conducted in different settings, with different legislative systems, and using different methods, invariably involved the loss of nuance and simplification of findings.

Implications for research and practice

Future research should explore whether factors such as diagnosis, age, ethnicity, relationship to the patient, models of inpatient and community care, and legislative arrangements influence carers' experiences of detention under mental health legislation. Research (ideally co-produced, including carers as partners) is also needed to explore how health service and other interventions can best facilitate carer involvement and provide effective support for them prior to, during, and after the detention of family members and friends.

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This report is based on independent research commissioned and funded by the National Institute for Health Research Policy Research Programme, through the NIHR Mental Health Policy Research Unit. The views expressed are those of the author(s) and not necessarily those of the NHS, the National Institute for Health Research, the Department of Health and Social Care or its arm's length bodies, and other Government Departments. A full report of this review will be submitted for publication in a peer-reviewed scientific journal.

A full report of this review has been submitted for publication in a peer-reviewed scientific journal.

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Crisis Planning Interventions for People with Psychotic Illness or Bipolar Disorder: A Systematic Review and Meta-Analyses

Summary for the Independent Review of the Mental Health Act

Authors: Emma Molyneaux, Amelia Turner, Bridget Candy, Sabine Landau, Sonia Johnson, Brynmor Lloyd-Evans

Introduction

Mental health services lack effective interventions to reduce compulsory admissions, and crisis planning interventions are one of the few which have been identified as being potentially beneficial [1]. Crisis plans describe in advance a person's preferences for treatment during a future mental health crisis, for example medications they find helpful or do not wish to take. Several different but overlapping forms of crisis plan exist, including Advance Decisions, Advance Statements and joint crisis plans, with variations in legal enforceability between countries and regions. No recent systematic reviews have been conducted which focus specifically on crisis planning interventions and provide detailed descriptions of the characteristics of the interventions, their outcomes, and the robustness of the evidence base in this area.

This review aimed to synthesise evidence from RCTs on the effectiveness of crisis planning interventions in reducing rates of compulsory hospital admissions for people with psychotic illness or bipolar disorder, compared with usual care.

Methods

Studies were eligible if:

- a. They included participants aged ≥ 16 years with a diagnosis of a psychotic illness or bipolar disorder with or without psychotic symptoms. Trials that include mixed populations of service users from secondary care mental health services were eligible if the majority of participants had a diagnosis of a psychotic illness or bipolar disorder.
- b. The intervention evaluated was any form of crisis planning intervention which involved the service user in decisions regarding future treatment preferences. Interventions that included follow-up meetings were eligible, if the primary aim of these meetings was to review the crisis plan.
- c. The comparison group received usual care.
- d. They were randomised controlled trials, including cluster randomised controlled trials.

Six databases (the Central Register of Controlled Trials, MEDLINE, EMBASE, PsycINFO, CINAHL and the International Standard Randomised Controlled Trial Number [ISRCTN] registry) were searched for relevant studies, without limitations for date or language of publication. Forward and backward citation tracking was conducted for all eligible studies and for two relevant systematic reviews [1, 2], to identify any additional relevant studies. Study screening was conducted by two reviewers and outcomes were extracted using a proforma developed for the study. Risk of bias assessment was conducted using the Cochrane tool for assessing risk of bias in RCTs.

For the primary outcome of compulsory psychiatric admission, a pooled risk ratio was calculated using random effects meta-analysis. Complete case analysis was used, and sensitivity analyses were performed to investigate the robustness of findings to changing assumptions regarding the mechanism of missing data. The secondary outcomes of interest were voluntary psychiatric admissions, total psychiatric admissions (i.e. compulsory and voluntary combined), duration of inpatient treatment, psychiatric symptoms or functioning, quality of life, therapeutic alliance, service engagement, perceived coercion, adverse effects and cost effectiveness. Random effects meta-analysis was used to pool data for each of the secondary outcomes, if three or more comparable studies were identified. If insufficient studies were identified for any planned analyses, narrative synthesis was used.

Results

Five eligible RCTs were included in this review. Studies were set in England (three studies), the Netherlands and Switzerland, and included data from a total of 1,340 participants.

Pooled data from the five included RCTs showed a reduction in risk of compulsory admissions among those receiving crisis planning interventions compared with usual care. This finding was robust to sensitivity analyses exploring the mechanisms of missing data.

There was no evidence that crisis planning interventions reduced the risk of voluntary or total psychiatric admissions (voluntary and compulsory combined). Few studies assessed other secondary outcomes.

Discussion

Our meta-analysis suggests that crisis planning interventions reduce the risk of compulsory admissions among individuals with psychotic illness or bipolar disorder. In contrast, there was no evidence for a reduction in voluntary admissions or total psychiatric admissions. Although the pooled estimate showed that crisis planning interventions were effective in reducing compulsory admissions, there was variation between individual studies both in the characteristics of the crisis planning intervention offered, and in whether the intervention was found to be effective.

Limitations

The conclusions of this review are limited by the small number of studies included, particularly for secondary outcomes. In addition, our review focused on crisis planning interventions for individuals with psychotic disorders and bipolar disorder, meaning that we are unable to draw conclusions about the effectiveness of these interventions for other groups at risk of compulsory admission.

Implications for research and practice

Several trials included in this review faced challenges in the implementation of the crisis planning interventions which may have limited their effectiveness and could reflect barriers to the use of these interventions in clinical practice. These potential barriers should be explored in future research and addressed in the implementation of these interventions. Research is also needed to explore the optimal model of delivery for crisis planning interventions and the mechanisms by which these interventions reduce compulsory admissions. Finally, future studies should examine whether the effectiveness of crisis planning interventions differs based on ethnicity, gender or other characteristics.

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This report is based on independent research commissioned and funded by the National Institute for Health Research Policy Research Programme, through the NIHR Mental Health Policy Research Unit. The views expressed are those of the author(s) and not necessarily those of the NHS, the National Institute for Health Research, the Department of Health and Social Care or its arm's length bodies, and other Government Departments.

A full report of this review has been submitted for publication in a peer-reviewed scientific journal.

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Compulsory Community Treatment to Prevent Readmission and Increase Engagement with Community Care: a Systematic Review and Meta-Analysis

Summary for the Independent Review of the Mental Health Act

Authors: Phoebe Barnett, Hannah Matthews, Brynmor Lloyd-Evans, Euan Mackay, Stephen Pilling and Sonia Johnson

Introduction

Compulsory Community Treatment (CCT) legally requires people with mental illness living in the community to adhere to treatment. CCT has been implemented in numerous countries in Europe, North America and Australasia. CCT may be implemented at the point of discharge from hospital, to prevent readmission, and/or for people living in the community at risk of relapse and hospital admission. CCT was introduced in England in 2008 following the 2007 Mental Health Act, in the form of Community Treatment Orders, applicable to patients on discharge from compulsory treatment in psychiatric hospital.

There have been several previous systematic reviews of CCT, but these have either been limited to randomised controlled trials(1), which risk including highly selected samples which may not be typical of the relevant clinical population; or include a broader range of study types but do not provide a quantitative synthesis of study findings(2-4).

This review aimed to provide an up to date review and quantitative synthesis of available evidence regarding the effectiveness of CCT in reducing readmission to hospital, inpatient service use, use of community mental health services and treatment adherence for patients with severe mental illness.

Methods

Studies were included if:

- a. At least 50% of patients had severe mental illness.
- b. The intervention evaluated was a form of CCT, defined as a legal requirement for patients to remain in contact with mental health services or accept treatment in the community. We excluded sentencing to compulsory treatment following a criminal offence.
- c. The comparison was with mental health patients not subject to CCT
- d. At least one of the following outcomes was reported: readmission to hospital, inpatient bed days, use of community mental health services, or treatment adherence.
- e. They were: randomised controlled trials, contemporaneous comparison studies comparing patients subject to CCT versus patients not subject to CCT; or pre-post studies comparing outcomes before and after the requirement for CCT.

Three databases (Medline, PsycINFO and EMBASE) were searched for relevant studies, without limitations for date or language of publication. Study screening was conducted by two reviewers, and data regarding study characteristics and outcomes were extracted using a proforma developed for the study.

For the primary analyses, pre-post comparison studies and two-group comparison studies (including randomised and non-randomised studies) were considered separately. Effect size statistics were converted to standardised mean difference with 95% confidence intervals, to allow comparison among studies using different outcome measures. A random effects model was used in analyses.

Results from: i) randomised and non-randomised two-group studies; ii) primary outcomes from studies; and iii) adjusted results from two-group comparison studies were also analysed in pre-planned sensitivity analyses. Any differences in study outcomes relating to: year of publication, duration of CCT follow-up, study quality or country were explored through meta-regression.

Results

Forty one studies were included in the review, comprising 17 pre-post comparison studies; 20 two-group comparison studies (including four papers reporting results from three randomised controlled trials); and four studies which reported both pre-post and two-group comparisons. Studies were set in the USA, European countries or Australia, and included in total data for n=189,749 patients.

Analysis of available data from n=21 pre-post comparison studies found large effect sizes for patients on CCT regarding: reduced readmission to hospital, reduced inpatient bed days, increase in community service use and increase in treatment adherence.

Analysis of data from n=20 two-group comparison studies by contrast, found no effect for CCT on readmission to hospital or inpatient bed days. There was a moderate effect for greater use of community services for patients on CCT, and a large but non-significant effect for increased treatment adherence from the two studies which assessed this.

Results regarding readmissions and bed use were similar in randomised and non-randomised two-group studies. However, randomised studies (n=2) found no effect for CCTs in community service use. Results for each outcome changed only minimally in two sensitivity analyses which included: i) only studies where this was the primary study outcome; and ii) adjusted results from two-group comparison studies. Meta-regressions found no discernible trends for better or worse outcomes from studies with respect to: year of publication, length of follow-up of CTO, country in which the study was conducted, or study quality.

Discussion

Available evidence does not suggest CCT has any effect in reducing readmissions to hospital or inpatient service use. Trials and non-randomised comparison studies found no effects for CCTs for these outcomes, regardless of study quality, duration of CCT or the date or country of the study. Although large improvements were found for patients following the use of CCT in pre-post comparisons, this may reflect the therapeutic effect of the previous hospital admission or regression to the mean following a period of severe illness, rather than any benefit from CCT.

Evidence from pre-post and two-group studies suggests that CCT does act as a mechanism for patients to receive more treatment and support from community mental health services. Whether this is because CCT improves treatment compliance, or just that patients on CCT are offered more care than others, is unclear.

Limitations

Although this review included over 40 studies, there were few trials and considerable heterogeneity regarding participant characteristics, study settings and types of CCT evaluated. Results of the review should therefore be interpreted with caution, although we believe the congruence in results from trials and non-randomised comparison studies increases confidence in the conclusion that CCT is ineffective in reducing readmissions or inpatient service use. This review did not systematically search for studies which evaluated other important outcomes from CCT, including patients' clinical and social outcomes, suicide and harm to others. We note that few of the studies included in this review evaluated any of these outcomes. We were unable to carry out planned meta-regressions for diagnostic group, ethnicity and gender due to lack of available data: it is possible that some clinical or demographic sub-groups of patients benefit from CCT while other groups are harmed by it. We did not evaluate the effectiveness of CCT for patient groups other than those with severe mental illness.

Implications for research and practice

There is little need for more pre-post or small, non-randomised comparison studies of the effectiveness of CCT in reducing admissions and inpatient service use. Further trials or large cohort studies (e.g. using national routinely collected data) could improve the current evidence base. More evaluation of the effect of CCT on other outcomes (e.g. suicide and clinical and social recovery) is also needed.

Evidence suggests CCT is ineffective in its primary aim of reducing readmissions. It requires time from clinical staff to administer and has associated costs: given its lack of effectiveness, it is unlikely to be cost-effective. Ensuring appropriate community care is provided to patients with severe mental illness, regardless of their legal status and whether they are subject to coercion, is a priority for mental health services.

A full report of this review has been published in *The Lancet Psychiatry*²⁸⁰:

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Interventions to reduce compulsory psychiatric admissions: a rapid evidence synthesis

Summary for the Independent Review of the Mental Health Act

Authors: Jessica K. Bone, Tayla McCloud, Hannah R. Scott, Karen Machin, Dr Sarah Markham, Karen Persaud, Professor Sonia Johnson, Dr Brynmor Lloyd-Evans

Background

Compulsory admissions are admissions to a hospital or mental health facility against an individual's will and according to local judicial procedures. These occur when people require urgent treatment for a mental health problem, often because they are at risk of harming themselves or others. Rates of compulsory admissions are increasing in several European countries. However, they are coercive in nature, often disliked by patients, and their therapeutic value remains uncertain. It is therefore important to identify which mental health services and interventions are effective in reducing compulsory psychiatric admissions.

²⁸⁰ <https://www.sciencedirect.com/science/article/pii/S2215036618303821?via%3Dihub>

A previous meta-analysis on this topic found very few effective interventions, with evidence only supporting the effectiveness of advance statements (crisis plans)¹. However, the search for this review was conducted in April 2015 so requires updating. It was also limited to trials of adult psychiatric patients (aged 18-65 years), but people of all ages are compulsorily admitted.

Our aim was to conduct an updated search for any evidence of an effect of relevant interventions on compulsory admissions, with wider scope than the previous review and including studies where compulsory admissions have been examined as a secondary outcome or adverse event.

Methods

A list was generated of 15 broad intervention types through discussion with experts, including the Working Group for the Independent Review of the Mental Health Act in England and the management group for the National Institute for Health Research Mental Health Policy Research Unit. Interventions were included if these groups considered that they might be relevant to reducing compulsory admissions. The included interventions were:

- Acute day units/day hospitals
- Adherence therapy/compliance therapy
- Advance statements/crisis plans
- Assertive community treatment/assertive outreach/intensive case management
- Cognitive behavioural therapy for psychosis (CBTp)
- Community rehabilitation services
- Compulsory community treatment/community treatment orders/involuntary outpatient commitment
- Crisis houses
- Crisis intervention/crisis resolution teams
- Early intervention services for psychosis (EIS)
- Family interventions for psychosis
- Housing interventions/supported housing/housing first interventions

- Open Dialogue
- Self-management/relapse prevention interventions
- Vocational interventions/supported employment/individual placement and support

Randomised controlled trials (RCTs) of these interventions were included if they reported compulsory admissions as an outcome or adverse event. Eligible studies compared interventions with another active treatment or treatment as usual for people with any mental health disorder. RCTs were identified through recent systematic reviews of each intervention, clinical guidelines for psychosis and bipolar disorder, and searching three databases for trials post-dating the most recent systematic reviews. We performed a narrative synthesis of the evidence for the effectiveness of each intervention in reducing compulsory admissions.

Results

No eligible RCTs reporting compulsory admissions were found for acute day units, community rehabilitation services, community treatment orders, family interventions for psychosis, housing interventions, Open Dialogue, or vocational interventions. The effects of these interventions on compulsory admissions therefore could not be evaluated.

Nineteen RCTs were identified that included compulsory admissions as an outcome or adverse event. Crisis plans and cognitive behavioural therapy for psychosis (CBTp) were evaluated by four RCTs each, adherence therapy and early intervention services for psychosis (EIS) were evaluated by three RCTs each, and two studies evaluated assertive community treatment. Only one study was found for each of crisis houses, crisis resolution teams, and self-management interventions.

Crisis planning interventions showed promising effectiveness. There was also evidence that a self-management programme with a crisis planning element reduced compulsory admissions, and mixed evidence regarding EIS teams. There was some evidence suggesting that adherence therapy, care from Crisis Resolution Teams, or Assertive Community Treatment did not reduce subsequent compulsory admissions. The included trials of CBTp and crisis houses only reported descriptive data on compulsory admissions, so their effectiveness could not be assessed fully.

Discussion

Evidence so far suggests crisis planning and self-management interventions (conceptually similar interventions) hold most promise in reducing compulsory admissions. The self-management programme overlapped in content with the four trial crisis plan interventions included in this review. All included a relapse prevention planning element, where participants are supported by a clinician to identify their early warning signs of relapse, plan personal coping strategies and helpful service responses, and share the resulting plan with their mental health care teams.

For many interventions, the trials included in our review represent only a small fraction of those published, as compulsory admissions are rarely included as an outcome measure. The majority of included trials recorded compulsory admissions as a secondary outcome or adverse event, and often small numbers of participants in both groups were admitted. These trials are therefore likely to have been underpowered to detect a significant difference between groups in terms of this outcome.

This rapid evidence synthesis used a broader search strategy than the previous systematic review¹, searching protocols and full texts for compulsory admissions data rather than only abstracts and titles of papers. In addition, a broad range of interventions were included, as well as international trials across a wide time period. Despite the wide scope of this review, we found only nineteen trials which measured the effect of a relevant intervention on compulsory psychiatric admissions.

Our rapid evidence synthesis was as systematic as possible, but not necessarily comprehensive. The review only included papers where compulsory admissions were clearly distinguishable from voluntary admissions, either in-text or through additional information provided by authors. This may have led to missed evidence from studies measuring compulsory admissions but referring to them only as 'admissions'. Due to the small number of eligible trials measuring compulsory admissions and heterogeneity within each intervention type, we did not conduct any quantitative synthesis of trial results.

The inconclusive findings on the effectiveness of most interventions for reducing compulsory admissions indicates a need for more research in this area. Of the interventions reviewed, crisis planning seems to be particularly promising in preventing compulsory admissions but further research is needed to confirm this and to establish the most effective intervention models and their mechanisms of effect.

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This report is based on independent research commissioned and funded by the National Institute for Health Research Policy Research Programme, through the NIHR Mental Health Policy Research Unit. The views expressed are those of the author(s) and not necessarily those of the NHS, the National Institute for Health Research, the Department of Health and Social Care or its arm's length bodies, and other Government Departments.

A full report of this review has been submitted for publication in a peer-reviewed scientific journal.

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Ethnic variations in detention under the mental health act: a Systematic Review and Meta-Analysis

Summary for the Independent Review of the Mental Health Act

Authors: Phoebe Barnett, Euan Mackay, Hannah Matthews, Rebecca Gate, Helen Greenwood, Kevin Ariyo, Kamaldeep Bhui, Kristoffer Halvorsrud, Stephen Pilling and Shubulade Smith

Introduction

Evidence suggests Black, Asian and Minority Ethnic (BAME) groups are at increased risk of involuntary psychiatric care. However, research is conflicted, with some studies reporting weak associations and some highlighting increased risk only in specific groups (1-3). This uncertainty undermines actions to reduce inequality and inform policy. A number of explanations have been put forward for the observed disparities, but few of these provide adequate supporting evidence (3). Previous meta-analyses have highlighted the importance of ethnic specificity in study design to allow a more comprehensive answer to reasons for inequality, but there has otherwise been little evidence to systematically update the pool of knowledge of the overrepresentation of BAME populations in the use of the MHA since its revision, and no systematic review or meta-analysis which takes an international perspective.

This review aims to update existing systematic reviews and meta-analyses (3-5) on the rates of detention for specific BAME populations, from an international perspective, and outline explanations for any disparity. Novel considerations of migrant populations are also given.

Methods

Studies were included if:

- a. At least two or more ethnic groups of any age were compared
- b. Risk of compulsory psychiatric care in minority, compared to majority ethnic groups was examined.
- c. At least one of the following outcomes was reported: Compulsory admission to hospital, compulsory readmission to hospital, or inpatient length of stay.
- d. Studies were quantitative in nature.

Five databases (MEDLINE, PsycINFO, EMBASE, CENTRAL and CINAHL) were searched for relevant studies in English. Study screening was conducted by two reviewers, and data regarding study characteristics and outcomes were extracted using a proforma developed for the study. Explanations given by studies for differences in psychiatric detention of BAME groups were also extracted, along with any supporting primary evidence.

Overall summary estimates were converted into odds ratios with 95% confidence intervals using a random effects model. Unlike previous studies, we attempted to avoid aggregate comparisons. Where possible, studies were retained in sub-groups of 'Black Caribbean', 'Black African', 'South Asian', and 'East Asian'. Studies solely reporting for 'Black' or 'Black other' groups were classified as "Black, unspecified". A further non-specific classification of "BAME unspecified" was constructed to contain studies reporting a mixture of minority ethnicities, e.g. "non-white British". We also conducted an analysis on studies comparing migrant groups (those born outside host country) to host populations. Our primary analysis compared rates of compulsory admission, readmission and length of stay.

The effect of study quality on results was explored, and metaregressions were conducted on mean age, proportion of females, publication year and national context (England and Wales, or international).

Results

Seventy studies were included in the review. Of these, 63 reported data which could be pooled in a meta-analysis. Black, unspecified, Black Caribbean and Black African groups were all significantly more likely to be compulsorily admitted than White Ethnic groups, and Black Caribbean groups were also significantly more likely to be readmitted. There was no significant effect on inpatient bed days though there was limited data for this outcome. Both South and East Asian ethnic groups were significantly more likely to be compulsorily admitted than White ethnic groups. Migrant populations were also significantly more likely to be compulsorily admitted.

Results from meta-regressions showed that UK studies reported significantly higher odds of compulsory admission in Black Ethnic groups than international studies, and that the proportion of the sample that was female predicted higher odds of detention in Black unspecified, Black Caribbean and South Asian groups. This remained significant when adjusting for age in Black unspecified and Black Caribbean groups. When including only studies scoring highly on the Ethnicity checklist, estimates remained significant. When including only studies rated highly with the Kmet quality assessment scale, results remained significant in all Black ethnic groups, but became non-significant in South Asian groups.

Of 70 studies, 12 offered no explanation of differences in psychiatric detention of BAME groups, 21 studies solely offered explanations unsupported by primary evidence, and 37 studies offered at least one explanation supported by primary evidence. Twenty-four classifications of explanations emerged over five domains, of which ten were unsupported by any of the included literature, seven had a mix of supporting and contradicting primary evidence, and seven were supported by primary evidence.

Discussion

Evidence here suggests that, as has been previously found, BAME groups are at a greater risk of compulsory detention than White majority groups, but that the literature lacks sufficient depth to draw causal inferences. Of the 70 papers in our review, nearly half offered no explanation of disparate risks of detention for minority groups, or solely offered explanations unsupported by primary evidence. This calls into question the scientific merit of study designs inadequate to explore explanatory factors across different ethnic groups, and which occlude further enquiry into the range of risks these groups are subject to.

Implications for research and practice: Only research committed to well-designed longitudinal studies and multisectoral, intersectional approaches will be able to untangle the causes of health care inequality in BAME groups, and thus inform practice.

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A full report of this review has been submitted for publication in a peer-reviewed scientific journal.

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Patterns of use of the Mental Health Act 1983 from 2009-10 to 2015-16 in Camden and Islington NHS Foundation Trust, London.

Summary for the Independent Review of the Mental Health Act

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Introduction

Detentions under the Mental Health Act 1983 are reported to have risen steadily over the past two decades (1). This study sought to explore trends in rates in detention over time for Camden and Islington NHS Foundation Trust, a mental health trust in London, replicating selected analyses conducted to investigate trends in detention at South London and Maudsley NHS Foundation Trust. Specifically, it examined whether there was (a) an increase in the percentage of patients who were detained at least once (i.e. more people being detained) or (b) an increase in the mean number of detention episodes initiated (for people with at least one detention in SLAM for that financial year) comparing each financial year (i.e. more people being re-detained), or both.

Methods

Data were extracted from the Case Register Interactive Search (CRIS) system at Camden and Islington NHS Foundation Trust, which provides approved research studies with access to de-identified clinical data from electronic mental health records (2). Individuals were included if they received 'active' care by Camden and Islington NHS Foundation Trust services any time in a given fiscal year during the observation period (from 2009-10 to 2015-16). For the purposes of these analyses we defined 'active' within Camden and Islington NHS Foundation Trust services as having a Camden and Islington NHS Foundation Trust ward stay for at least one day during the fiscal year(s) or participating in at least one face-to-face clinical encounter during that fiscal year. All analyses focused on working age adults (aged between 18 and 65 years, inclusive). We only included individuals from within the local Camden and Islington NHS Foundation Trust catchment (based on having either their GP or residential address within the boroughs of Camden or Islington; out of area placements were excluded). However, we included homeless people in the analysis. Analyses focused on episodes of detention under the MHA 1983

("detention episodes"). If there was a gap of more than 1 day between the end of one section and the start of a new section, this was considered a new detention episode.

Results

An increase in the number of patients who had at least one detention episode initiated per financial year was observed. However, findings indicated that the observed increase was predominantly due to an increase in the total number of patients being seen, with a small decline in the proportion of patients undergoing compulsory admission between 2009-10 and 2015-16. There was no apparent increase in the mean number of detention episodes for patients who had at least one day detained under the Mental Health Act between 2009-10 and 2015-16.

Discussion

The increase in number of detention episodes was less pronounced than may have been expected from national data and may mainly reflect the rise of the number of persons receiving mental healthcare.

Limitations

Findings come from a single NHS trust in London and may therefore not be representative of national trends in the use of the Mental Health Act. In particular, data are unlikely to be representative of rural and suburban areas and do not include adults aged older than 65 years. Analyses are descriptive and do not account for potential confounders that might explain changes in the use of the Mental Health Act over time.

Implications

Future research should include both investigation of this increase and multivariate analyses to investigate drivers of changes in the number of detentions under the MHA over time. Analyses should be replicated in trusts outside of London with access to systems such as CRIS and consideration given to developing similar systems in trusts currently lacking this type of data resource.

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This report is based on independent research commissioned and funded by the National Institute for Health Research Policy Research Programme, through the NIHR Mental Health Policy Research Unit. The views expressed are those of the author(s) and not necessarily those of the NHS, the National Institute for Health Research, the Department of Health and Social Care or its arm's length bodies, and other Government Departments. A full report of this review will be submitted for publication in a peer-reviewed scientific journal.

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Understanding increasing rates of detention in psychiatric hospital in England: development and preliminary testing of an explanatory model

Luke Sheridan Rains, Scott Weich, Clem Maddock, Shubulade Smith, Natasha Lyons, Lottie Millett, Sonia Johnson and Brynmor Lloyd-Evans (on behalf of the “Understanding the Rising Rates of Detention Topic Group” for the Independent Review of the Mental Health Act).

Introduction

Government data show that the total number of detentions under the MHA in England increased from 24,576 in 1988/9 to 63,049 in 2015/16. (This constitutes episodes of detentions; individual patients may be counted more than once if they have more than one compulsory hospital admission during a year. At end of year 2015/16, just over 20,000 patients were currently detained in hospital.) The rate of detentions per hundred thousand population in England more than doubled in this period, most sharply during the last decade: this rise is among the steepest among high-income countries(1). Men, younger adults (age 18-34) and people from BAME

and especially Black ethnic groups are over-represented among those detained, compared to their representation in the English population (2). But, due to the limitations of routinely collected (KP90) national data, we cannot say with confidence whether differential rates of detention for these groups have become more or less marked over time.

The rising rate of detentions was identified as the first issue of concern to be addressed by the Independent Mental Health Act Review(3). To support the Independent Review of the Mental Health Act in understanding the causes of this increase in detentions, this paper explored the plausibility of proposed explanations for their rising rate, and the extent to which each is supported or refuted by available evidence. An explanatory model of the rising rate of detentions was developed.

Methods

The study comprised four phases:

1. Hypothesis generation: A list of proposed explanatory factors for the rising rate of detentions in England since 1983 was generated from relevant reports and literature, and consultation with stakeholder reference groups from the MHA Review and the Mental Health Policy Research Unit, including people with academic and clinical expertise and first-hand knowledge through lived experience of mental health services. In keeping with Care Quality Commission report (4), we grouped proposed explanations into four categories: societal factors; service provision; legal issues; and data recording issues. Explanatory factors were developed where necessary into clearer hypotheses, describing the mechanisms through which they might contribute to an increase in detentions.
2. Hypothesis testing: We explored the plausibility of each proposed explanatory factor as a contributor to the rising rate of detentions in stages: i) Do available data suggest that rates of, or exposure to, the explanatory factor have changed over the period 1983-2016?; and if so ii) Does available research evidence suggest the factor is related to increased risk of detentions?; and iii) Is there any evidence of (a) any association between the potential explanatory variable and trends over time in compulsory detention at English national level and, where data are available, internationally and/or (b) any cross-sectional association at country or area level between the explanatory variable and compulsory detention rate?

3. Assessing the plausibility of hypotheses: Through discussion with an expert stakeholder reference group, we then rated the plausibility of each proposed explanatory factor as 0: contradicted by available evidence; 1: available evidence is ambiguous or lacking; 2: supported by available evidence.
4. Developing an explanatory model: Following guidance (5) and based on our hypotheses, we developed then refined a logic model to show how proposed contributory factors rated as potentially plausible might contribute to the rising rate of detentions in England, and how they might inter-relate. Contextual factors, service inputs, service activities and proximal outcomes were identified. Established and hypothesised elements of this explanatory model were differentiated.

Results

We identified 17 hypotheses for consideration regarding factors contributing to the rising rate of detentions in England (see Table 1).

From these hypotheses, we identified four factors which are likely to have contributed to the rising rate of detentions in England. First, the changes in the law following the Mental Capacity Act 2005 and subsequent case law mean that patients who lack capacity but are not actively objecting to admission are now more likely to be detained in hospital. Available research, based on a small, localised sample, suggested that, prior to 2007, as many as 20% of inpatients were non-objecting but lacking capacity to consent to admission (6); yet fewer than 4,000 Deprivation of Liberty (DOLS) applications were completed for patients in psychiatric hospitals last year (7). Thus, if MHA detention is now used for the remaining non-objecting patients who lack capacity, this could in theory explain nearly all the rise in detentions in the last decade. Although the exact extent of its impact is unknown, this is likely to be a significant contributor to the sharp rise in detentions since 2008.

Second, Adult Psychiatric Morbidity Survey data (8) suggest there may have been an increase in psychiatric morbidity in England, for common mental disorders and possibly for psychosis, which may increase the need for detention.

Third, NHS Digital Mental Health Bulletin data (9) indicate there has been a corresponding rise in the number of patients seen by secondary mental health services. Through this extended reach of mental health services, people who fit the criteria for detention may be more likely to be identified. Identification of people in potential need of detention by the police may also have increased: there has also been an increase in the number of people brought to a health-based Place of Safety by the police and subsequently detained, not all of whom might otherwise have accessed mental healthcare.

Fourth, numbers of detentions have been inflated in official statistics through double-counting of “transfers of care” for patients on section (10). It is possible this may have become more common in recent years if fewer inpatient beds and greater use of hospitals have led to people moving between hospitals more often during a detention.

The impact of mental health service change on detentions is less clear-cut. In England, the rise in detentions has been accompanied by a substantial reduction in inpatient beds. The rise in detention rates more commonly follows bed cuts than vice versa, indicating that some of this relationship may be causal (11). We note however, that internationally, more psychiatric bed provision is associated with higher rates of detention¹. A recent systematic review found no studies which have demonstrated an association between bed occupancy rates (a more direct marker of bed pressures) and rates of detention (12). The one large English study which explored this found no independent association (13), although this may reflect the capping of official bed occupancy statistics at 100%.

Regarding community services, evidence does not suggest that access to crisis alternatives to admission has reduced over the period since 1983, or in the last decade specifically. Available data (from the Mental Health Bulletin and NHS Reference Costs) indicate there has been a substantial rise in number of patients seen by community mental health services since 2003 and a corresponding decrease in the amount of money spent per patient in mental health services during this period. The number of contacts provided per patient has decreased in some service settings in the current decade, e.g. Community Mental Health Teams. Thus community mental health services may now be less equipped in some settings to provide intensive care where needed to prevent detentions. But we do not have a clear understanding of how the content of community mental health care delivered to patients may have changed over time, or of the service models and critical components of care which may best prevent detentions.

The precise contribution of changes in social, economic and demographic circumstances in England to detention rates since 1983 is also unclear. Given known over-represented groups among those detained (2,13), the ageing English population may mitigate the rising detention rate, but the increased representation of people from BAME groups (including Black African and White Other ethnic categories) might make a modest contribution to it. At population level in England, changes in levels of unemployment, income inequality, relative poverty and social fragmentation are not clearly associated with changes in detention rates, although some more nuanced markers of hardship (e.g. rates of benefits sanctions) do rise correspondingly, for periods where data are available. There may, however, be specific aspects of the experience and circumstances of the people who use mental health services that do not mirror the general population and are associated with

rising rates. Drug use, for example, appears to have declined in the general population (14) but to have increased among patients requiring inpatient admission in the past decade (15).

We have not found evidence that the introduction of the Mental Health Act 2007 contributed to the rising rate of detentions. We lack evidence about any impact on detention rates of the broader definition of mental disorder and changes to treatability criteria for detention which were introduced by this legislation. Evidence suggests that the introduction of compulsory community treatment in England in 2007, through Community Treatment Orders, is unlikely to have increased rates of detentions (16) (but nor does it appear to have reduced them).

Discussion: The broad scope of this paper means that we could not search systematically for evidence relevant to each proposed explanation. There was limited information available from official statistics about the nature of the rise in detentions, i.e. which demographic and clinical groups are most affected, and in what places. Our explorations of the associations between explanatory variables and changes in compulsory admission was limited by lack of relevant data, particularly regarding social and economic factors in the mental health patient population. We were also unable to explore the cumulative effect of exposure to multiple potential risk factors for detention and were limited in how far we could distinguish causation from association for many proposed explanations: all conclusions therefore remain provisional.

There is a pressing need for better data to allow us to understand the extent to which rates have really risen, and which patients have experienced the greatest increase in detention. We were unable to examine variation between groups of patients, and between places in these associations. Most importantly, we were not able to comment on changes in ethnic differences in rates of detention.

While using the least restrictive alternative in providing care is a guiding principle of the English Mental Health Act (17), it should be acknowledged that detention can in many cases be a necessary and helpful first step to supporting recovery, which is perceived as helpful in retrospect by about 50% of patients (18). We lack means to estimate with authority what rate of detentions is appropriate in any given service and social context.

A change in legal approaches to safeguarding the rights of patients who lack decision-making capacity, and rising levels of mental illness among the general population, may both be important explanatory factors in the rising rate of detentions. Mental health services and the police may also be getting better at identifying people who may meet criteria for detention. This does not mean, however, that improvements to mental health care and service provision cannot form part of the

solution to reducing detentions. Establishing the most appropriate, least restrictive means to safeguard the rights of vulnerable patients who lack decision-making capacity when admitted to hospital, and assessing whether community services are working in optimal ways and have the resources that they need, remain challenges for the whole mental health care system which may influence the trajectory of detention rates in the years to come.

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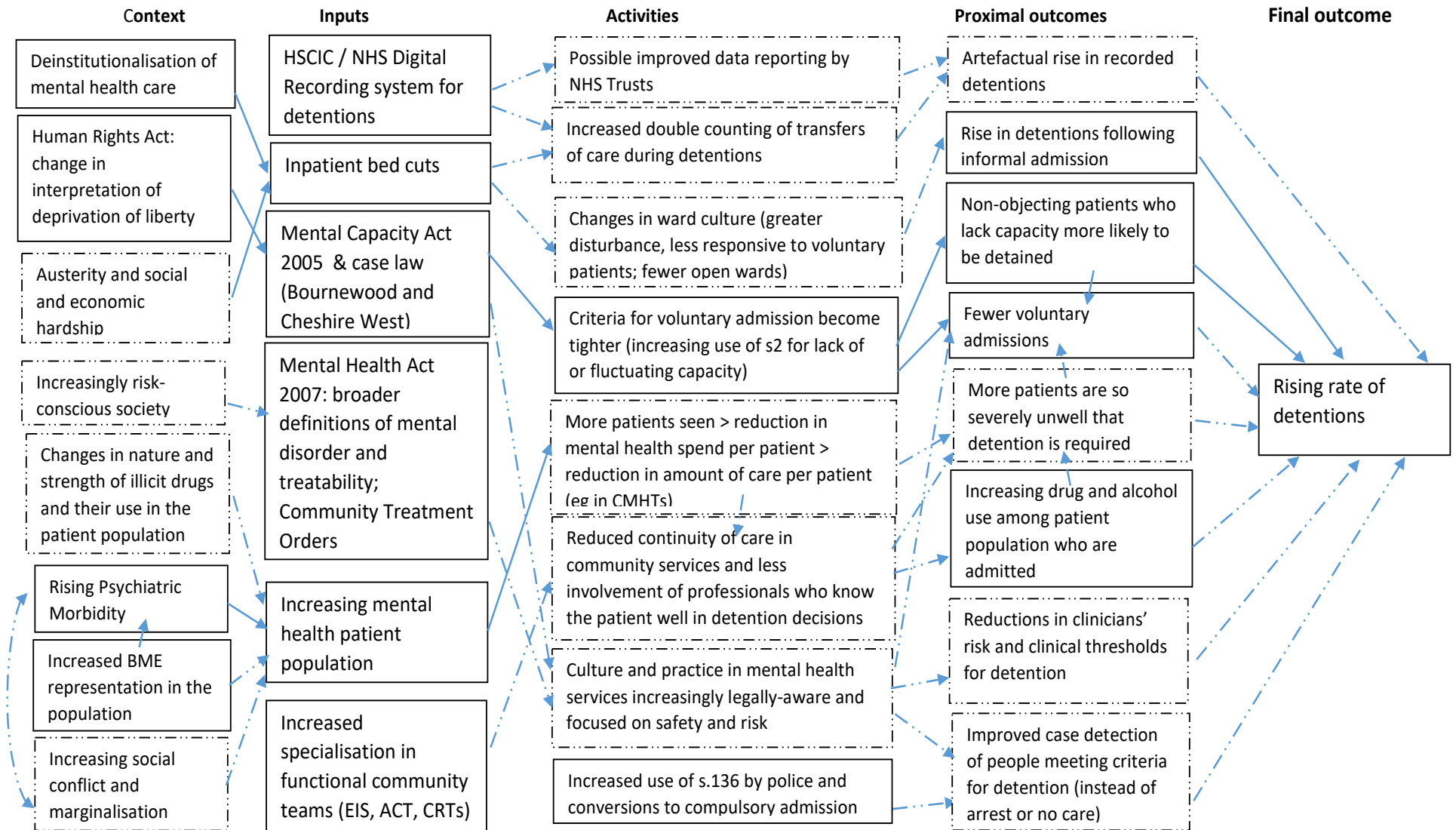
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Table 1: Hypotheses considered in developing an explanatory model for the rising rate of detentions in England

| Proposed contributory factors to the rising rate of detentions | Possible mechanisms (hypotheses): how might identified risk factors cause or modify the risk of detention? |
|---|---|
| Social factors | |
| 1. Social and economic hardship | Increased exposure to social stressors leads to more frequent relapses in the patient population and/or increase in rates of people developing a mental illness, leading to more detentions. (Social stressors could include: poverty, unemployment, social inequality, benefits sanctions, exposure to discrimination or hate crime) |
| 2. Increased drug and alcohol use | Increased substance misuse leads to increased risk of relapse in the patient population and/or increased rates of mental illness |
| 3. Demographic change (increased numbers of those at risk of detention) | Some demographic groups are at higher risk of detention than others: if the proportion of the population from these groups increases, we would expect higher rates of detention. |
| 4. Increasing rates of mental illness | A proportion of those with mental illness become so unwell that detention is required: higher rates of mental illness may lead to more detentions |
| 5. Reduced informal social support | The absence of informal support (and perhaps an increase in people living alone) leads to higher rates of relapse; and makes delivery of community-based crisis care difficult, and admission more likely; bed pressures result in the eventual need for detention |
| Service factors | |
| 6. Reduced availability and quality of community mental health services | Reductions in the reach of, or quantity and quality of care provided to current patients by, mental health community ongoing care services leads to reduced capacity to prevent detentions and increased rates of relapse, leading to more detentions. |
| 7. Reduced availability of alternatives to admission | Reduced availability of less restrictive community alternatives to admission leads to more compulsory admissions for patients not prepared to go into hospital |
| 8. Reduced quality and/or responsiveness of crisis services | Later intervention, or the lack of home treatment services, will result in more patients needing to be admitted. |
| 9. Reduced inpatient bed capacity | Lack of availability of beds (evidenced by reduction in bed numbers or increased bed occupancy rates) means that patients have longer to wait for a bed and are therefore more unwell at the time of admission; or are admitted involuntarily in order to secure a bed; or are discharged prematurely |

| | |
|---|--|
| | and therefore more vulnerable to relapse and compulsory readmission . |
| 10. Less continuity of care at MHA assessments | Assessment of risk may be more conservative (and overestimated) by professionals without prior knowledge of the patient. |
| 11. Increased among mental health professionals | S.12 doctors and AMHPs have become more likely to detain patients with a risk and clinical presentation which would not have led to detention in the past, due to changes in professional culture and attitudes to patient safety and risk management. |
| 12. Changes in prescribing practice | Reduced use of depot medication and/or clozapine over time has led to reduced medication adherence, resulting in more relapses and more detentions. |
| Legal factors | |
| 13. Impact of the European Declaration on Human Rights on legal and clinical practice re patients' decision-making capacity | Since the Mental Capacity Act, Bournemouth Judgement in 2008 and Cheshire West case in 2014, non-objecting patients who lack capacity who might previously have been admitted to hospital voluntarily are now more likely to be detained. |
| 14. Introduction of CTOs | i) There is a lower threshold for CTO recall than for admission following a MHA assessment, so CTO patients are recalled to hospital who would not otherwise have been detained, leading to an increase in CAs since introduction of CTOs in 2008. ii) CTOs are used as a means of facilitating early (premature) discharge, leading to frequent relapse and recall/readmission |
| 15. Police more likely to bring people to a Place of Safety on s135 or S136 | Increasing mental health awareness and use of s.135 and s.136 by the police leads to patients being brought to a place of safety and subsequently detained, who would previously have been arrested or left at home/in public places, and not all have been detained through other routes. |
| Data recording issues | |
| 16. Better data reporting in recent years | Service providers are submitting more complete data returns re detained patients over time, so under-reporting of detentions in official statistics reduces |
| 17. Increased double counting of detentions in official data | Increasing bed pressures lead to an increase in transfers between hospitals for patients during a detention (out of area NHS placements and use of private hospitals) leading to increased double counting of detentions in KP90 data. |

Understanding the rising rate of detentions in England 1983-2016: Provisional Logic Model



Variations in patterns of compulsory hospitalisation and in legal frameworks: an international comparative study

Summary for the Independent Review of the Mental Health Act

Authors: Luke Sheridan Rains, Tatiana Zenina, Marisa Casanova Dias, Rebecca Jones, Brynmor Lloyd-Evans, Sonia Johnson

Introduction

Rates of involuntary hospitalisation have previously been reported to vary widely between countries, with very little international evidence available as to how far this is due to differences in domestic legislation or else to socio-demographic, geographical or healthcare system variations.

The aims of the present paper are: 1) to compare rates of involuntary hospitalisation per 100,000 population in England and trends over time with those in other higher income countries with similarly developed mental health care services and legislation, 2) to compare national legislations and consider their relationship to rates of involuntary hospitalisation, and 3) to explore the association between rates and socioeconomic and healthcare provision indicators.

Methods

Data collection

21 countries were included: England, Northern Ireland, Scotland, Wales, Australia, Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Greece, Italy, The Netherlands, New Zealand, Norway, Portugal, Republic of Ireland, Spain, Sweden, and Switzerland. Countries were chosen based on having similar legislative and mental healthcare characteristics and having available involuntary hospitalisation data. Rates of involuntary hospitalisation per 100,000 of general population were obtained for 2008 to 2017 where available. Hospital admissions of forensic patients were excluded as the rationale and the legal frameworks regulating their detention are distinct from those considered here. Community treatment orders and similar community based involuntary assessment or treatment orders were also excluded, to maintain a focus on involuntary hospitalisation.

A profile was created for each country that summarised the relevant legislation. These were reviewed by key informants (psychiatrists or mental health legal experts based in the relevant countries and familiar with the legislation) to confirm their accuracy and comprehensiveness. The following socioeconomic and health care indicators were selected, and data were obtained for 2008 to 2017 for all countries where available:

- Number of psychiatric beds per 100,000 population,
- Healthcare spending per capita in USD (\$1,000's)
- Number of psychiatric staff (psychiatrists, mental health nurses, social workers, and psychologists) per 100,000 population
- Gross domestic product (GDP) per capita at purchasing power parity (PPP) in USD (\$1,000's)
- Income inequality (Gini coefficient)
- Absolute poverty (% of population below an income threshold of \$5.50 per day)
- Relative poverty (% of population with an income below half the national median)
- Urbanisation (% of population living in urban settings)
- Foreign-born population (% of population).
- Black and Ethnic Minority (BAME) population (% of population)

Data Analysis

The association between rates of involuntary hospitalisation and legislation was investigated regarding: whether the next of kin or a relative must be consulted in the involuntary hospitalisation process; whether treatment is required; whether a mental health professional or non-medical authority makes the decision to detain someone for the longest involuntary hospitalisation order; whether there is a distinction between assessment and treatment orders; the criteria for involuntary hospitalisation, including risk, lacking capacity, and treatability. In each case, rates were compared between countries with or without that legislative requirement using a. Associations between involuntary hospitalisation rates and socioeconomic and healthcare indicators were analysed to explore country-level factors associated with detention.

Results

Involuntary hospitalisation data

Across the countries studied, the rate of involuntary hospitalisations per hundred thousand population in the most recent year available ranges from 14.5 to 282. England is close to the median with an involuntary hospitalisation rate in 2016 of 114.1 per hundred thousand. However, the annual rate in England has risen faster over the last 10 years than most countries (average 4.0% annual increase). Among the other countries studies, rates of

involuntary hospitalisation have risen in some (e.g. France and Australia) but fallen in others (e.g. Ireland and Sweden).

Variations in Legislation

Internationally, mental health legislative frameworks regulating involuntary hospitalisation differed in a few key areas. These include the criteria for hospitalisation, such as whether risk to self or others is grounds for detaining someone, or who has the authority to issue hospitalisation orders, where in some countries, mental health professionals primarily make the decision while in other countries it is judges. In many countries there are distinct emergency, assessment, and treatment orders. But the specifics of the distinct detention orders vary quite widely between countries. Overall, however, analyses found no evidence that rates of involuntary hospitalisation were related to differences in legislation.

The Human Rights of patients are becoming an increasingly important consideration, with several countries either having or currently being in the process of reforming legislation to improve respect for patients' rights. In Ireland, for example, the Mental Health Act 2001 was primarily intended to improve patients' rights by introducing measures such as increasing the involvement of patients in the involuntary hospitalisation decision-making process, introducing tribunals, and by applying a principle of assumed capacity.

Socioeconomics and health care provision

There was evidence that involuntary hospitalisation rates were positively associated with psychiatric bed provision rates and inversely associated with the proportion of the population living in absolute poverty (i.e. countries with fewer people living in poverty and with more psychiatric beds tended to have higher rates of involuntary admission). There was little or no evidence of any association with other socioeconomic or healthcare indicators.

Discussion

England's rate of involuntary hospitalisation is approximately average across the included countries, but rates are rising faster than most other countries. In England, a fairly large proportion of the overall number of involuntary hospitalisations, as well as the rise in the rate over the last 10 years is attributable, to the (increasing) use of short-term involuntary assessment orders¹ that exist in English law but not in all countries.

Our results do not suggest any association between differences in legislation and rates of involuntary hospitalisation. Thus it may be that legislation affects clinical practice relatively little, with clinical staff navigating whatever requirements are in place for compulsory detention once the decision has been made to detain someone.

Our results suggest that wealthier countries that have more inpatient psychiatric healthcare provision tend to have higher rates of involuntary hospitalisation. However, the overall pattern of results demonstrates that this issue is complex. While internationally the provision of psychiatric inpatient facilities is positively associated with rates of involuntary hospitalisations, in England psychiatric bed numbers have been declining while rates of involuntary hospitalisation have been rising². Further research is required especially on the relationship to involuntary admissions of socioeconomic factors and healthcare provision, informed by an awareness of the distinctive characteristics of individual countries and the fact that socio-demographic trends among people with mental illnesses may not closely reflect those in the country as a whole.

A full report of this review has been submitted for publication in a peer-reviewed scientific journal.

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A qualitative exploration of perspectives on the Mental Health Act and people of African and Caribbean descent: summary

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Background

People of African and Caribbean heritage are significantly more likely to be detained under the Mental Health Act (MHA) than members of any other main ethnic groups. Black²⁸¹ service users' access to mental health services via adverse care pathways and inferior experiences of care have been reported for several decades, representing some the greatest and most intractable disparities in mental healthcare provision. However, the voices of African and Caribbean service users and carers in relation to detention under the MHA are seldom heard. Gaining insight into their experiences would facilitate understanding of present service challenges and help to identify opportunities for improvement. The Mental Health Act Review African and Caribbean group (MHARAC) therefore determined that it was vital to hear directly from these key stakeholders about their experiences and perceptions of the MHA.

Aims

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

²⁸¹ 'Black' is capitalised to highlight that 'Blackness' is about more than skin colour, emphasising the racialised position of African descended people in contemporary society.

Methods

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

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

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

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

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

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

Key findings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"All you need to do is look at all the psychologist (...) they're usually White. They're usually female. None of them, studied, ya know, transcultural therapy. So they don't know what you know and then they say (...) the person's not therapeutically minded" (AMHP 2, P1, London)

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

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

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

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

Summary

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

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

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

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

Annex D: Qualitative analysis of the Service User and Carer Mental Health Act survey

See document published with the Report.

Our Recommendations

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 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 DoLS/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, NHSI, 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 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 IMHAs 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 (DoLS, in future the 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 CTOs should be revised in line with detention criteria.
58. The onus should be on the RC 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 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 RC 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, IMHA 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 CMHTs, 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 IMHA 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 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 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.**

The Review Team

Chair:

Simon Wessely

Vice Chairs:

Steve Gilbert, Mark Hedley, Julia Neuberger

(Henry Globe served as a vice chair from October – December 2017 before moving on due to other commitments. He was replaced by Mark Hedley)

Secretary:

Richard Kelly

Secretariat:

Alasdair Anderson, Amy Brodie, Sophie Carruthers, Helen Farmer, Jennifer Harris, Esther Horner, Gabriel Lawson, Matthew Lees, Katy Lindfield, Ben Lumley, Sarah Palmer, Graham Sale, Rachel Seabrook, Charlotte Tuck

Working group advising the review leadership:

Andy Bell, Sophie Corlett, Kim Forrester, Steve Gilbert, Danielle Hamm, Viral Kantaria, Alex Kennedy, Alex Ruck Keene, Kate King, Brynmor Lloyd-Evans, Clementine Maddock, Shubulade Smith, Mark Trewin, Simon Wessely

Note: the individuals above may not have served for the whole review period and may now be in other roles.

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 Act 1989 | An Act relating to children and young people and those with parental responsibility for them |

| Key terms | Definition |
|---|---|
| Code of Practice | Shows professionals how to carry out their roles and 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 | The European Convention for the Protection of Human Rights and Fundamental Freedoms. The substantive rights it guarantees are |

| Key terms | Definition |
|------------------------------------|--|
| Human Rights | largely incorporated into UK law by the Human Rights Act 1998 |
| Human Rights | Substantive rights set out in the European Convention on Human Rights |
| Independent Mental Health Advocate | A person providing advocacy under the provisions of the Mental Health Act 1983 |
| 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 |

| Key terms | Definition |
|---------------------------------|---|
| Responsible Clinician | The Responsible Clinician has overall responsibility for care and treatment for service users being assessed and treated under the 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 |

| Key terms | Definition |
|------------------|--|
| | patient, to contain behaviour that threatens harm to others |
| Tribunal | The First Tier Tribunal is an independent panel that can discharge 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 |