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Briefing

Modernising the Mental Health Act

Professor Sir Simon Wessely's independent review of the Mental Health Act 1983 is entitled *Modernising the Mental Health Act: Increasing choice, reducing compulsion*

Introduction

The report runs to over 300 pages but is helpfully split up into chapters focussing on the four key principles that they recommend are included in an amended Mental Health Act (MHA):

- Choice and Autonomy
- Least Restriction
- Therapeutic Benefit
- The person as an individual

The recommendations as a whole are set out at pages 282-299.

There are helpful, summary infographics at pages 44-46 too.

We look at each of these in turn and highlight some of the key recommendations, from a legal perspective, relating to each one.

Principle 1: Choice and Autonomy

Patient voice (pages 67-72)

The principle objective in the review was to increase the number of ways a patient's voice is heard, recorded and considered.

Aims of the review

- Increase patient involvement by making shared decision-making the basis, as a far as possible, for care planning and treatment decisions made under the Act.
- Establish a new basis for making treatment decisions which respects the patient's expertise and the knowledge of the clinician.
- Make 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.

While legislative changes are recommended to shift the balance of power towards the patient the review acknowledge that culture change is also needed.

They are keen to emphasise that they do not expect clinicians to make treatment decisions which have no clinical benefit. However, they also explain that just as medications have untoward side effects, there are also untoward side effects from imposing decisions about treatment against a person's preferences. They are not recommending changing the definition of medical treatment for mental disorder.

Treatment (pages 72-73)

Their approach to treatment is set out at Annex A of the report (see pages 223-230). Three categories of treatment are proposed to apply to all patients whether they be in hospital or in the community (including those detained under Part III):

- Category 1: Treatments which may only be given with consent.
- Category 2: Treatment refusals made with capacity or in an Advance Choice Document can only be overruled by the authorisation of a judge.
- Category 3: All other treatments.

The review accepts that their recommendations here will only be effective if recommendations on shared decision-making and advance choices are also put in place. They recommend that in cases where a patient is treated against their will, despite having capacity, the records would need to be lodged with the MHA administrator and be subject to scrutiny by Care Quality Commission.

Challenging treatment decisions (pages 73-75)

The review proposes two new ways of challenging treatment decisions.

- Patient should be able to request a Second Opinion Appointed Doctor (SOAD) from the point at which the care and treatment plan is finalised, (or 14 days after admission, whichever is earlier).
- At the moment the only way to challenge the decision of a Responsible Clinician (RC) and SOAD is to bring a Judicial Review challenge. The review are of the view that this is too expensive and too difficult. They recommend a route of challenge to a Tribunal judge, supported by non-means tested legal aid. Permission would have to be granted first. Assuming it was then a judge would have the power either to require the RC to reconsider the 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. Like any Tribunal decision a provider would be able to appeal to the Upper Tribunal.

The review states that the Government and CQC will need to work together to resolve the resourcing issue here.

Advance Choices (pages 75-79)

Advance Choices Documents (ACD) are recommended to enable adults to make a range of choices and statements about their care and treatment.

If they are made by a person with capacity, they can be authenticated by a healthcare professional and should then be treated in the same way as treatment choices made at the time. This is to remove the potential for doubt later. A pilot is recommended.

A standard format with 11 areas is suggested (see pages 76/77) including eg, behaviour and behaviour triggers and early signs of relapse/preferences or refusals on how treatments are administered/crisis planning.

They are clear that no ACD can be made that would contradict the wishes of parliament around assisted dying.

The ideal is that they would be created collaboratively, reviewed regularly and updated.

If a person lacks capacity the review is clear that they should still be encouraged to express wishes in advance of a potential crisis using the same form as an ACD. But it would not be authenticated, so would not hold the additional weight.

They suggest storing ACDs on a national database, but in the meantime being stored on the health and care provider's database, flagged on the Personal Health Record and recorded in the statutory care plan.

Consenting to admission in advance (pages 79-81)

Apparently few issues caused as much discussion during the course of the review as this one.

No firm recommendation was made other than that the Government should consult further on this.

Nearest Relatives (pages 82-87)

To be replaced by Nominated Persons (NP).
A patient is to be allowed to choose their own NP either prior to detention, at the point of assessment or while detained. If they have capacity they can also "opt out" from having one.

If the patient lacks capacity then an Interim NP (INP) would be appointed by the Approved Mental Health Act Professional (AMHP) when making the application for detention.

The review recommends not just that an NP is "notified" about renewals, extensions of Community Treatment Orders (CTOs) and transfers from one hospital to another but that they are "consulted". In addition, with patient consent, they are to be consulted regarding care plans.

With regard to Part III patients a limited NP provision is recommended (without the right to discharge).

With regard to treatment, where a patient is unable to appeal a clinical treatment decision, the review recommends an NP should be able to appeal them.

Involvement of others (pages 85-86)

In addition to an NP, the review recommends that patients should be given the opportunity to record who else they would like to receive information about their care. One of the aims being to help staff to share information without worrying about potential breaches of patient confidentiality.

Advocacy (pages 87-92)

The review wants to enhance and extend advocacy provision – this includes to informal patients and those in the community. It is said that by making this a statutory role it will prevent it being seen as an "optional extra" by commissioners.

It is proposed that Independent Mental Health Advocates (IMHAs) should be able to challenge treatment decisions, make applications for discharge and challenge treatment (where the patient lacks capacity).

Complaints (pages 92-93)

Section 132 to be amended to include information on making complaints, including through digital means.

People employed to deal with complaints should have an understanding of the MHA.

Board papers should disaggregate complaints from informal patients versus detained patients.

Investigations, Learning from Deaths and Serious Incidents (pages 96-99)

Although the review is not recommending an independent investigation in every case where a detained patient dies, they do think that non means-tested legal aid should be available for families of those who have died unnaturally, violently or by suicide to help them understand the processes, their rights and what steps they can take, including funding to attend the inquest.

With regard to Deprivation of Liberty Safeguards, the review recommends that guidance (from the Chief Coroner and in the MHA Code of Practice) makes it clear that where a patient deprived of their liberty in a psychiatric hospital dies it should be presumed that the individual is in state detention for the purposes of triggering the duty for an investigation by a coroner.

Given that the review heard time and time again that lessons are not being shared nationally following serious or fatal incidents they think it is crucial that mechanisms are put in place nationally to make sure this happens.

ACDs, advocacy and NPs have been referred to as “game changers” in the report.

Principle 2: Least Restriction

Risk Aversion (pages 104 - 106)

The review heard anecdotal reports about their having been a shift in the perception of what is “acceptable” risk following cases like *Rabone*.

They think that health organisations would benefit from liaising and engaging with coroners to develop a shared understanding of the decision-making processes for detention and the reasons behind them.

They were also concerned that risk assessments were not carried out consistently. Further, it was noted that the existing standardised assessment tools are not ideal because they are designed to fit a generic patient rather than being tailored.

Criteria for Detention (pages 106 – 110)

In order to give informal admission more prominence the first recommendation is that section 131 is moved so that it sits above section 2 and section 3 of the MHA.

In order to be detained, the review are of the view that a patient must be objecting to admission or treatment, otherwise they should be admitted informally or under DoLS.

With regard to formal patients, the review is concerned that the current criteria for detention are too vague and rely too heavily on whether or not someone has a mental disorder. They are of the view that the bar is currently set “too low”. Concern was expressed by service users that they are seen as “risk entities, rather than as human beings...”

The review recommends that the Act is 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. They recommend that there must be a “substantial likelihood of significant harm” backed up by evidence but acknowledge that mental health professionals deciding to accept a greater perceived risk will not work if courts, regulators, the media and others do the opposite.

In particular, the review recommends that the AMHP would clearly state on the application form what specific harm they have identified, how detention will reduce this, including why alternatives are not available or suitable. They are keen to ensure that a short term emergency risk does not become an unnecessarily long-term detention.

In terms of treatment, it is recommended that this is also something that is said to benefit the patient in terms of contributing to the patient’s discharge. In addition, the review are clear that consideration must be given to community alternatives and it must be clear that the person cannot be treated in the community.

They also state that continuing detention should not 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 therapeutic benefit.

Statutory Care and Treatment Plan (pages 110-114)

This is central to the review’s recommendations. They describe it as their cornerstone because it delivers on all four of the key principles.

They recommend that one is developed soon after detention, within seven calendar days for a section 2 or section 3. It should then be reviewed or signed off by a clinical director or delegated officer at 14 days to ensure it is appropriate and it is being adhered to.

They are clear that it is not intended to increase the burden on professionals.

Tribunals are to scrutinise the Care and Treatment Plan (CTP) during each application for discharge and, if they have any concerns, adjourn proceedings while the hospital addresses them.

Initially the plans could just include giving someone brief respite but it is recommended that the plan be developed (covering ten points set out at page 111) and then updated before renewals and appeals to the Tribunal.

Length of Detention (pages 114 – 118)

The aim here is to ensure that sections 2 and 3 are both used as originally intended. The review were concerned that section 2 is used too often for patients who are well known to services. They are particularly worried about disadvantaging such patients in respect of section 117 aftercare.

For section 2 the recommendations include:

- RC to develop the CTP within seven calendar days so that the justification for continued detention is re-assessed within the first week.
- CTP to be reviewed after 14 days by clinical director/delegated officer. The aim would then be:
    - For the patient to be moved to section 3 with a clear account of why detention is needed/what it seeks to achieve.
    - For the patient to be discharged.
    - For clear reasons to be given for a maximum 14 day extension of section 2.
- 21 days to apply to Tribunal for discharge (not 14).
- Code of Practice to be amended so that if AMHP is aware that a person has been subject to detention under section 3 in the last 12 months, an application under section 2 can only be made where there has been a material change.
- Code of Practice to make clear that section 3 should be used when a person has already been subject to section 2 in the last 12 months.
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For section 3 the recommendations include:

- The first period of detention be halved to three months, renewable after a further three months, then a further six months, making three detention periods in the first year.
- RC and AMHP to certify the continuing need for detention ten days in advance of a Tribunal hearing.

Challenging Detention: Tribunals (Pages 118 – 122)

The review recommends that when a Tribunal have decided not to discharge a patient they should be able to make directions concerning leave or moves to lower levels of security.

Having looked at the powers of the Special Educational Needs Tribunal the review recommends limited powers to direct that treatment and care be provided in the community, if it is clear that, without those services, the patient would have to remain detained in hospital. The aim here is to try to unblock services which are preventing a patient's release.

Where Tribunal judges come across example of breaches of human rights in respect of care and treatment the review would like them to have the power to refer these cases to CQC.

In addition, in order to help the Tribunal understand the context of service provision and what is available for the patient, the review thinks that it would be helpful if the Tribunal was provided with performance information for their local providers eg, on average lengths of stay and incidents of violence, for example.

In light of the amendments to section 3 proposed above the review recommends:

- An increase in the current number of challenges a patient can make from two to three, one for each period of detention in year one.
- A new power for SOADs and CQC to refer a patient to the Tribunal if there is a material change in circumstances.

New powers are also recommended to allow IMHAs and Nominated Persons to exercise patients' rights to apply on their behalf.

However, full costings have not been modelled so the Government will need to undertake a full impact analysis.

Deprivation of Liberty Safeguards (pages 122-127)

The review 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. They were particularly concerned to hear stories about the MHA being used instead of DoLS because it was easier to use.

They want to amend the Mental Capacity Act so that only the MCA framework can be used where a person lacks capacity to consent to their admission or treatment for mental disorder and it is clear they are not objecting. They accept that objection is not always easy to identify and suggest that the process should be started while the position is investigated (for no more than 72 hours).

Community Treatment Orders (pages 128-135)

The review intends to halve the use of CTOs and make sure they are only used where they are the least restrictive option. If within five years, there is no reduction/no increase in effectiveness, then they recommend that CTOs are reviewed again, with a view to removing them. They think it should be hard to restrict a person's liberty with a CTO.

They appreciate that in the short term their recommendations will increase the workload for Tribunals and for clinicians but believe that the changes will lead to a reduction in CTOs and so, in the longer term, will deliver cost and time savings.

Their recommendations increase safeguards at every stage, so that decisions are never made by a single professional and require a higher burden of proof for their use/continued use.

Making a CTO

- It must be shown that previous disengagement led to a significant decline in mental health.
- CTO's unlikely to be used after a first detention.
- NP or INP to be informed and be able to object to making of CTO.
- Decision to make CTO should be taken by two Approved Clinicians (ACs) (one of whom must be the community supervising clinician) and the AMHP.
- Renewals to involve two ACs and an AMHP.
- Expectation that CTOs end after two years.

Challenging a CTO

- Tribunals to have a power to remove conditions they think are unnecessary.
- Better IMHA services for people on CTOs to enable them to appeal.

Recall

- Recall criteria to include substantial risk of significant harm if patient not recalled.
- Government to consider option of recalling patient to community services (not necessarily those connected to a hospital).

A related point made covers Guardianship. The review believe this should still be available.

Principle 3: Therapeutic Benefit

Section 117 aftercare (pages 138-141)

The review want to avoid inequality in the system. They note that patients with equitable needs informally admitted or admitted under section 2 do not receive section 117 aftercare, and therefore often receive less support in the community to manage their mental disorder/prevent readmission.

They would like to have recommended expanding aftercare to such patients (and to those subject to DoLS whose primary reason for being in hospital was for treatment for mental disorder). However, they see that the only way this could be done, within the existing financial envelope, would be to place tighter parameters around section 117 provision which they felt would run the risk of further inequalities for those in greatest need.

They also heard about inconsistencies in the way section 117 is administered.

They hope the Green Paper on social care for adults provides an opportunity here. Its publication has been further delayed – it will now be published “at the first opportunity in 2019”.

Statutory Care Plan (pages 141-142)

This is to encompass rights under the Care Act, NHS Continuing Healthcare, personalised budgets and section 117 aftercare.

They are of the view that putting care planning on a statutory footing will support more consistent application.
It is to include ACDs.

They envisage a single digital document which, as one benefit, would save patients having to repeatedly tell different services and institutions about their care needs.

Joint Working (pages 143-144)

The review are recommending that legislation is amended to include a duty for Clinical Commissioning Groups 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 would be supported by a clear statement in the Code of Practice on the purpose of both SCPs and section 117 aftercare.

They suggest national guidance setting out how budgets and responsibilities should be shared for section 117 aftercare.

They also touch on Ordinary Residence and suggest rules are aligned across health and social care, with additional guidance covering those placed in another area, with provision of financial adjustment for some regions.

The SCP should set out who is responsible for what elements of an individual’s care.

They suggest the Government and NHS England form a national view on how much is being spent on section 117 aftercare, by whom and on what.

Hospital Visitors (pages 145-147)

The review recommend removing Hospital Managers' hearings to consider discharge, as they think it duplicates the role of the Tribunal and does not represent an effective use of scarce resources.

Instead, the review suggest a new role of monitoring day to day life in the hospital, ensuring that patients are treated with dignity and respect, that they receive the treatment they need and that their rights are protected.

Principle 4: The Person as an Individual

Tribunals (page 156-157)

- The review recommend that the Judicial College 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.
- Statistics are needed on ethnicity to help understand the experience of the Tribunal system of patients from ethnic minority communities.

Organisational Competence Framework (pages 159-161)

The review recommend that this is developed initially by the NHS but then rolled out to wider public services.

It would be to support organisations fulfil their existing obligations under the Equality Act 2010, specifically the Public Sector Equality Duty.

They note the ongoing NHS England work to develop an Organisational Competency Framework for mental health.

Children and Young People (pages 167 – 177)

The review is concerned that the current legal position is complicated in relation to the admission and treatment of children and young people and they think it should be clearer.

16/17 year olds

For a 16/17 year old, they recommend that the only test that should apply when deciding whether they can consent to admission or treatment should be that set out in the MCA. They hope that the Supreme Court decision in Re D resolves the issue but, if not, they state the MHA should make it clear.

If a young person has capacity to consent to admission and does not agree, then the review agree that they cannot be admitted as an informal patient on the basis of parental consent.

If a young person lacks capacity to consent to admission, then they think they should be treated as an adult, and that deprivation of liberty needs to be authorised. If they are objecting, the review state that the MHA would have to be used, but if they are not objecting then DoLS/Liberty Protection Safeguards (LPS) authorisation should be obtained.

They point out that this does not exclude parents – they will still be involved, either through a parent being the INP or through the consultation process required in the proposed LPS. They also recommend that the importance of their role is strengthened in the Code of Practice.

With regard to treatment, again, the review think 16/17 year olds should be treated like adults. If the 16/17 year old has capacity, the review recommend that the MHA puts beyond doubt that a parent cannot consent on their behalf if they refuse treatment.

Under 16s
They found this area harder and found a range of strongly contrasting views within the review. They therefore recommend that the Government consult widely on this issue.

For both categories, they recommend that parents and carers should have:
- A right to advocacy.
- A right to be involved in care and treatment planning meetings.
- Support to ensure they can afford to travel when they are hospitalised out of area.

They recommend that the Government consider whether reviews should be put on a statutory footing when a child or young person is an informal patient.

Learning Disability and Autism (pages 177-180)

Changes to detention criteria are covered above. The review think it is too easy for the behaviour of a person with a learning disability, autism or both to reach the current threshold of risk.

They believe that there should be a "substantial risk of significant harm" and want the harm specified on the application form.

In addition, new treatment criteria will prevent "warehousing" of patients without treatment. The new criteria proposed are that treatment must benefit the patient and that it cannot be delivered without detention. Hence, alternative interventions in the community must be considered first.

Challenging Treatment Decisions (page 180)

Access to SOADs and a right to appeal treatment decisions to a Tribunal will, the review believe, 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.

Code of Practice (page 182)

Many amendments to the MHA Code of Practice are suggested, including:
- Application of the Code's statutory authority to NHS commissioners.
- The MHA should be used with caution for people with a learning disability, autism or both.
- The Code should protect against the overuse of medication and the underlying principles of STOMP should be reflected.
- Reminding clinicians of their responsibility to arrange and/or provide care for physical health issues.
- Requiring clinicians to acknowledge that someone's behaviour may be a result of a problem unconnected with their mental disorder and therefore mental health treatment may not be effective.

Police (pages 184-190)

Several recommendations are made including:
- Police cells should be removed altogether as a place of safety in the Act by 2023/24.
- The Act should be changed so that it specifies that the preferred place of safety under section 135/6 is defined as a "health based place of safety" or "section 136 suite".

- A national agreement between mental health services and the police setting out how people detained under section136 should be safely "handed over" to health services and the circumstances under which police officers may be required to stay at health settings.
- NHS England should invest capital and revenue to improve the ambulance fleet for mental health conveyance, although the Code of Practice should also be made clearer about those cases in which police transportation may be preferable eg, extreme urgency or risk of violence.
- NHS England and the CQC to work with CCGs, Local Authorities and the AMHP Leads Network 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 with regard to arrangements being in place for the reception of patients in special urgency more effectively and consistently.

Criminal Justice (pages 191-197)

Several concerns are expressed in this section of the report.

In light of this, they recommend that a new role is created to oversee the process of assessment and admission of prisoner from prison to hospital. They suggest it is independent of both the prison and the NHS and suggest it could be similar to AMHPs for civil patients. They hope that this would unblock institutional barriers. New statutory time frames are also recommended in order to give the role teeth to push transfers through.

With regard to decisions in respect of restricted patients by the Justice Secretary, it is suggested that the CTP are used by the Mental Health Casework Service to allocate each patient a category, reflecting the level of complexity around decisions to be made. Then, for decisions that are straightforward or carry little risk, the RC would take the decision, giving notice to MHCS who would have 14 days to object.

Tribunals cannot currently direct leave or transfer to another hospital and the review think this should change. Given the recent Supreme Court decision in MM they also recommend that the Government legislate to give Tribunals power to discharge patients with conditions that restrict their freedom in the community, potentially with a new set of safeguards.

The review are concerned that 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. While this is wrong for them, the review are also concerned that they are taking up valuable bed space and obstructing efforts to transfer people in from prison.

Conclusion (page 219)

The review concludes by saying that given the range of differing views and the complexity of both the law and the operational landscape their attempt to change things for the better has not been easy! They accept that it is not likely that they have managed to give everybody precisely what they had hoped for, but they hope that everyone finds something that will make a meaningful and positive change for them.

Professor Sir Simon Wessely ends the review with an "afterword". While he claims to be no Mystic Meg, he expects real change in and revitalisation of community services as well as a new offer for those with learning disabilities and autism. Both of which he describes as essential, if the goals the review have set are to be achieved. He quite rightly notes that legislation can only achieve so much.

If you have any questions about the review or the Mental Health Act, please get in touch with me or your usual Mills & Reeve contact.

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