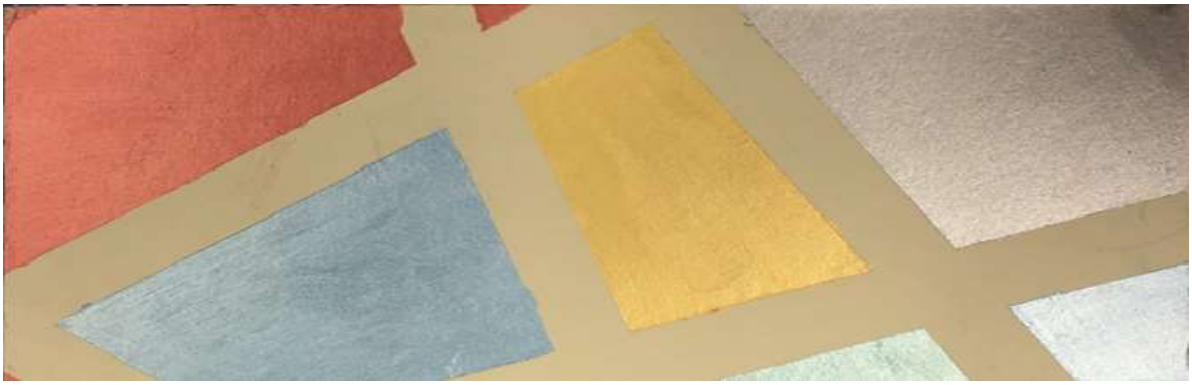
DISCUSSION PAPER: MODERNISING THE MENTAL HEALTH ACT

January 2021



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A: Introduction

1. After over two years, the government has now set out its full response to the Independent Review led by Sir Simon Wessely, as well as a public consultation on its proposals which ends on 21 April 2021. The vast majority (but not all) of the Review's 154 recommendations have either been accepted or at least in principle. A Draft Bill will be prepared in 2022 and considered when parliamentary time allows. The Welsh government is to provide its own response to the Review in due course. Rather than replacing the MHA 1983, the plan is to amend/modernise it (like in 2007). This paper analyses those proposals which specifically relate to law reform and does not consider the other important proposals, such as access and waiting time standards for urgent and emergency mental health care, or the building of two new mental health hospitals with eight further schemes planned

B: A Matter of Principle

2. Similar to the MCA 2005 approach, there will be four statutory principles incorporated into the Act and embedded into practice to govern every element of a person's care. As a result, they will be more legally weighty than those presently confined to the Code of Practice and will be:

    a. Choice and autonomy – ensuring service users' views and choices are respected

    b. Least restriction – ensuring the Act's powers are used in the least restrictive way

The picture at the top, "*Colourful*," is by Geoffrey Files, a young man with autism. We are very grateful to him and his family for permission to use his artwork.

c. Therapeutic benefit – ensuring patients are supported to get better, so they can be discharged from the Act

d. The person as an individual – ensuring patients are viewed and treated as individuals

3. Insofar as mentally disordered offenders (MHA Part 3) are concerned, the government will be considering the compatibility of these principles. It will also be interesting to see what legal consequences may flow from breaching them.

C: Civil Admission Criteria

(a) 'Mental disorder' – autism and/or learning disability

4. A more nuanced approach to the admission of those with autism and/or learning disability is proposed. Admission under s.2 would still be a legal option but only when their behaviour is so distressed that there is a substantial risk of significant harm to self or others (as for all detentions) and, importantly, a probable mental health cause to that behaviour warrants assessment in hospital. The White Paper states, "*The intention is that this additional behaviour 'qualification' would strengthen and expand the current qualification for learning disability to include an assessment of what is driving abnormally aggressive behaviour or seriously irresponsible conduct.*" The aim of the assessment is then to identify whether a mental health condition is the driver of the behaviour. Community Care, (Education) and Treatment Reviews ('CETRs') will play a significant role in admission decisions. There will also be a statutory requirement for the responsible clinician ('RC') to consider the findings and recommendations of CETRs in the care and treatment plan. Any deviation must be justified and explained.

5. Significantly, for the purposes of s.3 autism and/or learning disability will not count as a mental disorder. So unless there is some mental health condition to justify such detention, s.3 will simply not be an option. This will mean that if, for example, the behavioural driver is a physical condition, unmet support need, unmet social or emotional need, or unmet physical health need, s.3 will not be available. The purpose here is to ensure that those with autism/learning disability are not inappropriately detained in mental health hospitals. But will that purpose be achieved, or will the forthcoming Liberty Protection Safeguards take over? This will depend upon the interface between the MHA and MCA (there being no suggestion that the LPS will be amended so as to remove autism/learning disability from the definition of 'mental disorder' grounding lawful deprivation of liberty in this context).

(b) Interface with MCA

6. The government's final response to the Law Commission's LPS proposals was that "*The Government has commissioned a wide-ranging and independent review into the Mental Health Act and it is more appropriate for the issue around the Mental Health Act/Mental Capacity Act interface to be considered as part of this*". However, the White Paper states: "*Given that the new LPS framework is yet to come*

into effect and may serve to address issues raised by the Review, we agree with the Review that it is important to assess the impact of its implementation, before introducing these reforms to the MCA/MHA interface." So no legislative changes are yet proposed, and more guidance will be given in the MCA/LPS Code of Practice around the interface.

7. What this means is that where someone with autism/learning disability is, for example, detained under MHA s.2 and there is no mental health condition, MHA s.3 will not be available but if incapacity is proven and the hospital confinement is necessary and proportionate to the risk of harm to the person, they could remain detained in hospital under LPS. This is particularly so, given that it will be hospital staff conducting the LPS assessments and (in the NHS) hospital managers authorising detention. This will of course not be an option in respect of those with the relevant capacity.

8. The MHA will still be available for those who have decision-making capacity. But the statutory forms will be amended so that a patient's capacity to consent to their admission must always be assessed and recorded at the admission stage. The White Paper envisages a role for advance consent to informal admission but wishes to consult on it as the person would lose the relevant MHA/LPS safeguards. The White Paper agrees that dual authorisation under MHA s.17 and DoLS/LPS should not be needed and will clarify this in the Code.

9. The Review proposed that the Mental Capacity (Amendment) Act should itself be amended so that a person could be held in hospital for up to 72 hours under LPS whilst it is determined whether they are objecting. The White Paper agrees that emergency powers are needed, especially in Accident and Emergency, but the Government indicated that it would prefer to extend the remit of the holding powers in MHA s.5 to make that 72-hour power available in Accident and Emergency and exercisable only by senior clinicians; the White Paper is, though, consulting specifically upon whether the amended MCA powers are sufficient. It will be interesting to see what respondents to the consultation have to say about how this should bear upon the challenges around MHA s.136 issues. In that regard, the White Paper commits to remove police stations as places of safety by 2023-24 once the system is ready.

(c) Raising the risk

10. The civil risk threshold will be raised to whether there is "*a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person*". This criterion will apply to ss2-3, CTOs, renewals and tribunal applications for discharge. This is likely to result in less use of the Act which is one of the government's key aims. No such change is proposed for MHA Part 3.

(d) Therapeutic benefit purpose

11. Section 3 (but not s.2 or Part 3) will be amended to require the medical recommendations to demonstrate that:

a. The purpose of care and treatment is to bring about a therapeutic benefit;

b. Care and treatment cannot be delivered to the individual without their detention; and

c. Appropriate care and treatment is available.

12. Limbs (b) and (c) are similar to the current law so everyone's attention will be on (a). The MHA presently states that medical treatment must have a therapeutic purpose (MHA s.145). So how this criterion is phrased in the Bill will be critical as last time there were significant debates regarding the differences between therapeutic 'likelihood' and therapeutic 'purpose'. Is 'purpose' sufficient, or must it be shown that detention is *likely* to provide therapeutic benefit?

13. The government defines 'therapeutic benefit' as "*the purpose of detention is always about helping patients to recover and supporting them towards discharge*". If that is what is meant by therapeutic benefit, this amendment may ultimately be disappointing: for when is that not currently the purpose of MHA-detentions? Consultation question 2 asks whether we agree that "*detention must provide a therapeutic benefit to the individual*". Most respondents are likely to agree but exactly how this criterion is phrased will be incredibly important. Rather than a meaningful criterion for admission, there is a risk that it might be too easily satisfied; similar to "appropriate medical treatment" being available.

(e) Timescales

14. Section 2 will remain for up to 28 days but the deadline for applying to the tribunal will increase from 14 to 21 days. In relation to s.3, the maximum detention periods will be changed from 6, 6, 12 months to 3, 3, 6, 12 months. As a result, someone detained under s.3 will have three rather than two opportunities to apply to the tribunal in the first year.

D: Treatment for Mental Disorder

(a) Advance Choice Documents ('ACDs')

15. Anyone with decision-making capacity can create an ACD but there will be a legal requirement to offer an ACD to all those previously detained under the MHA. They will be stored and readily accessible on a secure digital database. Similar to the MCA 2005 approach to advance decisions, capacity need not be formally certified at the time of creation and the ACD comes into effect when the person subsequently loses capacity. But, unlike the MCA, they the refusals contained in such documents will not (if valid and applicable) be legally binding . Instead, there will be a legal requirement to 'consider' ACDs if the person subsequently loses decisional capacity. The content of an ACD will include:

- Any treatments the person does not wish to consent to as well as their preferred clinically appropriate treatments

- Preferences and refusals on how treatments are administered (e.g. refusal of suppositories, and preference for care staff of a particular gender, to avoid retraumatising them, given the relationship between gender-based violence and trauma)
- Name of their chosen Nominated Person
- Names of anyone who should be informed of their detention, care and treatment (including specific instructions on which individual should get what information)
- Communication preferences
- Behaviours to be aware of which may indicate early signs of relapse
- Circumstances which may indicate that the person has lost the relevant capacity to make relevant decisions
- Religious or cultural requirements
- Crisis planning arrangements, including information about care of children/other dependents, pets, employment, housing etc.
- Other health needs and/or reasonable adjustments that might be required for individuals with a disability or learning disability and for autistic people.

(b) Care and Treatment Plans ('CTPs')

16. Legislating for what is currently best practice, there will be a duty on responsible clinicians ('RCs') to formulate a detailed care and treatment plan for each person within 7 days of being detained which, following scrutiny, is then approved by a Medical or Clinical Director (or equivalent) within 14 days of detention. It is thereafter a living document which governs everything up to and including leave and discharge:

    - The full range of treatment and support available to the patient (which may be provided by a range of health and care organisations)
    - For patients who have the relevant capacity and are able to consent, any care which could be delivered without compulsory treatment
    - Why the compulsory elements of treatment are needed
    - What is the least restrictive way in which the care could be delivered
    - Any areas of unmet need (medical and social) e.g. where the patient's preferred treatment is unavailable at the hospital
    - Planning for discharge and estimated discharge dates (with a link to s117 aftercare)

- How ACDs and the current and past wishes of the patient (and family and/or carers, where appropriate) have informed the plan, including any reasons why these should not be followed
- For people with a learning disability, or autistic people, how Care (Education) and Treatment Reviews, where available, have informed the plan, including any reasons why these should not be followed
- An acknowledgement of any protected characteristics, e.g. any known cultural needs, and how the plan will take account of these
- A plan for readmittance after discharge e.g. informal admission, use of civil sections, or recall by the Justice Secretary

17. Note, therefore, that a key component will be the wishes and preferences of the patient to ensure that:
    - Capacitous decisions are followed wherever possible.
    - If lacking capacity with an ACD, the ACD will inform development of the CTP.
    - If lacking capacity without an ACD, the RC must still support the person to express wishes and preferences and consult with the nominated person (see below), family, and carers.
18. Crucially, where a person's wishes are not followed, the RC must provide the rationale. And where treatment refusals are overruled, the CTP must document how the relevant procedures were complied with (see below).

(c) Challenging compulsory treatment

19. MHA Part 4 is one of the most controversial parts of the Act and the proposals here are quite significant. The safeguards, like now, depend upon the invasiveness of the psychiatric treatment which is divided into three categories:
20. Category 1 (most invasive): relates to MHA s.57 and no changes are proposed. So neurosurgery and surgical implantation of hormones will continue to require capacitous consent and a second opinion appointed doctor ('SOAD').
21. Category 2 (invasive): relates to MHA s.58A with some changes.
    - Those with capacity (at present or in advance via an ACD) can refuse electro-convulsive therapy which, like now, cannot be overridden unless ECT is necessary to save life or to prevent a serious deterioration (s.62(1)(a)-(b)). The major change, however, is that before doing so the RC will require approval from a High Court Judge, supported by two medical opinions.

- If lacking capacity with no ACD refusal, like now a SOAD will be required. But there will be a greater need for the SOAD to ascertain the patient's wishes and preferences and where appropriate consult with the NP, family etc. If ECT is necessary to save life or to prevent a serious deterioration (s.62(1)(a)-(b)), it can be given prior to SOAD approval but the CQC must be informed, and the RC's records must be provided for scrutiny.

22. Category 3 (all other medication for mental disorder): relates to MHA s.58 and here is the most significant change:

    - Those with capacity (at present or in advance via an ACD) who refuse medication are entitled to a SOAD at day 14 of detention (when the CTP is signed off) rather than within 3 months as at present. Note, therefore, that capacitous refusals can still be overridden, but the SOAD is involved much earlier. And rather than merely deciding whether the treatment is 'appropriate', the SOAD will consider best interests and whether there is "no other clinically appropriate treatment available that is more acceptable to the patient". In emergencies, medication can be given under s.62(a), (b) and (d) but not (c). As a result, those refusing psychiatric medication cannot be urgently treated to alleviate serious suffering, which is referred to in the White Paper as "the right to choose to suffer".

    - If lacking capacity with no ACD refusal, a SOAD will be required within 2, rather than the present 3 months. Again, the SOAD will consider best interests. And emergency treatment can be provided under the full scope of s.62, including where it is immediately necessary to alleviate serious suffering by the patient.

23. Note, therefore, that there is not an absolute right to refuse treatment for mental disorder in the same way as for physical disorder. According to the White Paper, that would contradict the therapeutic benefit principle. But the circumstances in which refusals can be overridden will be much more circumscribed because of the SOAD changes and the new High Court Judge safeguard. Moreover, where compulsory treatment is required, it should only be administered in lowest possible dose to be effective and for shortest period to achieve its purpose. And there will be a right to challenge certain treatment issues in the tribunal (see below).

E: Community Treatment Orders

(a) Criteria

24. Like the civil admission criteria, these will be amended to require substantial likelihood of significant harm and therapeutic benefit. The White Paper variously refers to the fact that the CTO "will provide a therapeutic benefit" and patients "would receive genuine therapeutic benefit from the structure". So, again, the purpose or likelihood of such benefit will depend on how the criterion is exactly phrased. However, it says these new requirements should not create a barrier to prevent patients from being discharged to a CTO, when this represents the least restrictive option.

(b) Personnel

25. There are two main changes here. First, the involvement of not just the RC and AMHP but also the community supervising clinician at both the outset and for every renewal of the CTO. And, second, a new right for the NP to object to the CTO (unless overruled).

(c) Length of CTOs

26. The Code of Practice will provide an expectation that CTOs will end after 2 years (or sooner) so that patients are discharged unless they have relapsed or deteriorated during that time.

(d) Other changes

27. The tribunal will have a new power to recommend a reconsideration of the CTO conditions. However, the tribunal will not be able to recommend changes to those conditions that would impact on clinical treatment. Maintaining consistency with the detention criteria, recall will require the higher risk threshold, namely substantial risk of significant harm. Interesting, though, a patient can be recalled not just to a hospital but to non-hospital locations at the RC's discretion. The automatic tribunal referral when a CTO is revoked will also be removed.

F: Improving support for people who are detained

(a) Nominated person

28. The nearest relative will be replaced by the nominated person ('NP') which will not be determined by a legal hierarchy like it is at present. Patients can nominate a person in their ACD, in the absence of which the patient will be asked to nominate during the MHA assessment. Those with capacity can decide not to have an NP. If they lack capacity to do so, and if no-one has been previously nominated, the AMHP will appoint an interim NP until the patient has capacity to make their own nomination. Patients can also identify those they wish to receive information about their care and treatment.

29. In addition to the rights and powers that nearest relatives presently have, the NP will also:

- Have the right to be consulted on care and treatment plans to ensure they can provide information on the patient's wishes and preferences;
- Be consulted, rather than just notified (as now), when it comes to transfers between hospitals, and renewals and extensions to the patient's detention or CTO;
- Be able to appeal clinical treatment decisions to the tribunal, if the patient lacks the relevant capacity to do so themselves and the appeal criteria are met;
- Have the power to object to the use of a CTO if it is in the best interests of the patient.

30. Part 3 patients will also be provided with an NP, but their powers will be more limited to care and treatment planning.

31. The nearest relative displacement provisions will be reformed. So an NP who objects to a s.3 or CTO (and presumably to guardianship) can be temporarily overruled (rather than displaced) which means they will still be involved in care and treatment planning. The grounds for overruling are not yet set out. Whether the current role of the County Court should transfer to tribunals is being consulted upon.

(b) Advocacy

32. The plan is to expand the IMHA role to:

- Support patients to take part in care planning and ACDs
- Challenge a particular treatment where they have reason to believe that it is not in the patient's best interests
- Apply to the tribunal on the patient's behalf.

33. Whether IMHAs will be available for informal patients (like presently in Wales) will be subject to future funding decisions. Moreover, a pilot programme of culturally sensitive advocates will be launched to identify how to respond appropriately to the diverse BAME needs.

G: Tribunals

(a) Tribunal referrals

34. Addressing the issues considered in *SM v Livewell*, there will be a new power for IMHAs to apply to the tribunal on behalf of a patient. A power to vary the periods for automatic reviews along the following lines will be introduced, but any such changes would be phased in over time:

- Section 3: change 6 months to 4 months, and 3 years to 12 months.
- CTO: keep the 6-month referral but change subsequent 3 years to 12 months, and remove automatic referral when a CTO is revoked.
- Part 3: change 3 years to 12 months.
- Conditional discharges: new automatic referral at 24 months and then every 4 years.

(b) Recent confirmations

35. The plan is to require the RC to certify 10 days in advance of a s.3 tribunal hearing that the patient continues to meet the detention criteria. Consideration will also be given to whether CTPs might replace some of the existing tribunal reports to reduce paperwork and bureaucracy.

(c) Expanding the jurisdiction

36. There are two significant aspects to this:

37. Leave, transfer, and community services: as part of a discharge application, the tribunal will have the power to grant leave, transfer patients, and direct community services for unrestricted (but not restricted) patients. There will be a duty on the relevant public body to take all reasonable steps to comply with the tribunal's decision within 5 weeks. Failure to do so will require explanation, setting out the steps taken and why it was not possible.

38. Treatment reviews: where patients refuse psychiatric treatment (either presently with capacity or via an ACD if now lacking capacity), if given permission by the tribunal judge they can challenge the treatment if:

- The RC and SOAD have confirmed that the treatment should be given and have set out the reasons for overruling the patient's refusal;
- The patient, or their NP or IMHA, has set out the treatment refusal and rationale for it;
- The application applies to a specific disagreement about an individual treatment decision, rather than a general desire not to be detained, or to not receive treatment; and
- Any repeat application shows a material change in circumstances.

39. If permission is granted, a single Judge will then determine whether the appropriate processes have been taken by the RC in overruling the refusal. It is not therefore a full merits review but more akin to the approach taken in judicial reviews. The White Paper states:

> *"The judge would not take any role in clinical decision-making and they would not be able to authorise the use of a specific treatment. However, the judge would be able to make a finding that the Responsible Clinician should reconsider their treatment decision. The Review also recommended that the Tribunal should be able to order that a specific treatment is not given if it is found to disproportionately interfere with a patient's rights. We wish to consult on this point."*

40. Therefore, those lacking without ACD cannot challenge treatment in the tribunal. It is not immediately obvious why. Presumably the incapacitated would only be able to challenge their treatment through judicial review proceedings. This gives rise to a certain lack of parity between those refusing with capacity (either presently or with the wherewithal of having an ACD in place) and those lacking capacity who may be vehemently objecting the specific treatment but have not planned ahead through an ACD. It may well be that this is tested further as the consultative and legislative processes proceed, although against a backdrop of the fact that there are ultimately hard decisions to be taken as to the balance of Tribunal time/resource to allocate as between considering whether detention is justified and considering individual treatment decisions.

H: Caring for patients in the Criminal Justice System

41. The Part 3 criteria for admission will not be reformed (even where the patient has a learning disability or autism) but a limited NP role will be created. The aim is to ensure that Part 3 patients are able to access care and treatment at the earliest and quickest opportunity, that decisions made over their care are timely and that patients are able to access sufficient information about their rights, and that they receive the necessary support. The government is consulting on how this will best be done in respect of transfers from prison to hospital. Reforming diversion from the criminal justice system will be considered alongside the wider reform proposals of the Law Commission's Unfitness to Plead report. The Lord Chancellor has also set out how the government plans to support people with neurodivergent conditions such as autism and dyslexia, as well as those with acute mental health problems, within the criminal justice system.

42. In relation to restricted patients, there will be a new 'supervised discharge' power that can authorise a deprivation of liberty which will be annually reviewed by the tribunal. It will be applicable where the patient:

- Is no longer therapeutically benefitting from hospital detention; but
- Continues to pose a level of risk which would requires a degree of supervision and control amounting to a deprivation of their liberty; and so, could not be managed via a conditional discharge; and
- This would be the only least restrictive alternative to hospital.

43. Such a proposal would thereby address the difficulties arising from the decision in *MM*.

I: Children and Young People

44. It is proposed that CTPs are prepared for all children and young people receiving inpatient care including on an informal basis. Reflecting the Supreme Court's decision in *Re D,* parental consent cannot be provided to authorise the deprivation of liberty of a 16-17 year old. For those under 16, the government is minded to leave the issue with the courts. One thorny issue relates to the interface between *Gillick* competency and capacity which the White Paper says ought to be a matter for the Code of Practice rather than legislative change to the MHA.

J: Useful resources

45. Useful free websites include:

- www.39essex.com/resources-and-training/mental-capacity-law – database of guidance notes (including as to capacity assessment) case summaries and case comments from the monthly 39 Essex Chambers Mental Capacity Law Report, to which a free subscription can be obtained

by emailing marketing@39essex.com.

- www.mclap.org.uk – website set up by Alex with forums, papers and other resources with a view to enabling professionals of all hues to 'do' the MCA 2005 better. It has a specific page of resources relating to COVID-19 and the MCA 2005.
- www.lpslaw.co.uk – a website set up by Neil which includes videos, papers and other materials (much of them free) relating both to the Liberty Protection Safeguards and the MCA 2005 more widely
- www.mentalhealthlawonline.co.uk – extensive site containing legislation, case transcripts and other useful material relating to both the Mental Capacity Act 2005 and Mental Health Act 1983. It has transcripts for more Court of Protection cases than any other site (including subscription-only sites), as well as an extremely useful discussion list.
- www.scie.org.uk/mca-directory/ - the Social Care Institute of Excellence database of materials relating to the MCA.

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