



ASSOCIATION OF CLINICAL PSYCHOLOGISTS

ACPUK Response  
MHA Reform White  
Paper 2021

The Association of Clinical Psychology UK (ACP-UK) represents Clinical Psychologists working across a range of mental and physical healthcare environments, within the NHS and in private practice. There are over 1000 members and more than 14,000 qualified clinical psychologists in the UK.

The aim of ACP-UK is to empower clinical psychologists to provide a psychological perspective in order to improve the wellbeing and quality of life of service users and the general public. We do this by promoting evidence-based psychological principles and opinion as applied to contemporary issues in health and social care at national and local levels.

ACP-UK surveyed members about the Mental Health Act Reform White Paper. The views represented here reflect the responses of the 30 respondents and steering group members.

## Summary

- We welcome the principles of Choice and Autonomy, Least Restriction, Therapeutic Benefit and the Person as an Individual. We believe there should be a legal requirement for all parties acting within the legislation to adhere to these principles.
- The principles of the Mental Capacity Act (MCA) should take precedence. Autonomy, capacity and choice, not 'mental disorder' should govern decision making. Choice and Autonomy should be privileged. Where capacity is fluctuating, decisions should be guided by advance choice documents and care plans previously collaboratively developed. Early completion and easy availability of these should be mandatory.
- The continued prominence of the medical diagnostic model of functional 'mental disorder' within the MHA perpetuates psychopharmacology as the primary treatment of mental distress. People with psychosis for example report avoiding disclosing their experiences for fear of the impact on their human rights and medicalisation of their mental distress. Psychological, social and occupational therapeutic interventions should be equally available. All interventions should be based on a culturally informed understanding of the individuals experience and needs.
- We welcome the more frequent review of detention. There should be pervasive emphasis on human rights and the restoration of autonomy.
- Psychologists, nurses, occupational therapists and social workers have been successfully deployed as Approved Clinicians. All Approved Clinicians should be able to gain Section 12 approval. Giving service users

a choice of the profession of their Responsible Clinician should be mandatory.

- Second Opinion Appointed Doctors (SOADs) are medical practitioners. This perpetuates a medical focus to mental health treatment. The role should be broadened, to other suitably qualified practitioners e.g. Approved Clinicians from other professional disciplines.
- Many of the inequalities experienced by marginalised groups and communities are outside of the mental health system but influence how mental health services are operated. Action is required on the wider determinants of health in order to further reduce these disparities. A more progressive, psychologically informed approach that integrates mental health, physical health, understanding and respect for culture and belief is required. The reformed MHA should specifically be assessed against measures that ensure it will be enacted equitably. The implementation of the Patient and Carers Race Equality Framework (PCREF) and access to a culturally appropriate advocate should be mandatory.
- Modernising the Mental Health Act is an opportunity to instigate a review of all practices that may be discriminatory such as the current automatic suspension of a person's driving licence for a minimum of three months when they are diagnosed with a number of psychiatric disorders. When a person is detained such decisions should be made on a case by case basis by a Responsible Clinician

## Part 1

### Chapter 1: New guiding principles.

#### **Q1. Embedding the principles in the MHA and the MHA Code of Practice.**

It is important to embed the principles in law, and also within the new Code of Practice. They also need to be integral to the forms completed throughout detention under the MHA.

The principles should be embedded in Trust policies, and training for health and social care professionals. Services should be set up in ways which are focused on choice, autonomy, the person at the centre and therapeutic benefit so they are embedded within secondary care community and inpatient care pathway processes e.g. choice of lead professional, care planning documentation.

Application of the principles, e.g. therapeutic benefit, will only be possible with adequate funding supporting 'best practice' and access to a range of psychological, occupational and social therapeutic interventions so that decisions are made on the evidence base and not based on the resources

available. Too often, psychopharmacological treatment and nursing care are the only options available.

The service user should have the right to choose the profession of their AC/RC. This option is important where the primary mental health needs are psychological rather than medical. It would further enable choice between being viewed through a diagnostic or therapeutic/holistic lens. This necessitates equity in availability of ACs from Clinical Psychology, Nursing, Social Work and Occupational Therapy.

We recommend Section 12 approval is expanded to include ACs who are Clinical Psychologists. To attain Approved Clinician status Clinical Psychologists must attend training and demonstrate the ability to appropriately assess whether the individual's needs meet the criteria for detention under the MHA and ongoing detention under the act, therefore have the skills required.

People need appropriate, timely and adequate information and advocacy support to understand their rights.

Regulatory reviews should ensure the implementation of the principles in practice. Good practice frameworks e.g. AIMS can also help to ensure principles are embedded in care provision and will need to be adapted to incorporate the requirements of the new act.

## Chapter 2: Changes to the detention criteria

ACP-UK believes that it is inappropriate and unethical to provide for the compulsory treatment of people who are able to make valid decisions about their health care. In physical care, such decisions are not legal, and we believe the principle of non-discrimination means that such decisions should not be taken in the case of people with mental disorders.

There should be a distinction between those presenting with risk to themselves due to impairment in cognition, versus those with impaired capacity due to the presence of an acute extreme psychological state caused by emotional distress. The latter represent a distinct group who are at risk both of being allowed to harm themselves due to the assessment of statutory services that they 'have capacity' to do so, and also of being inappropriately detained due to fleeting if extreme psychological states.

We strongly recommend that the conditions for compulsion are amended to reflect the principle that people whose capacity to make decisions about their health care is unimpaired should retain their right to decide their own treatment. We recommend, therefore, that a further condition is added – "that because of the mental disorder the patient's ability to make decisions about the provision of such medical treatment is significantly impaired". This

wording appears in the Mental Health (Care and Treatment) (Scotland) Act 2003.

## **Q2. Ensuring detention must provide therapeutic benefit to the individual.**

87% of respondents strongly agreed/agreed that detention must provide therapeutic benefit to the individual.

The MHA White Paper is predicated on assumptions about 'diagnosable mental illnesses' which many mental health professionals dispute, and that psychological distress is always underpinned by disease analogous to physical disease whose principal treatment is medical. Legislation should be informed by biological models, but a broader, psychological, social, and culturally informed conceptualisation of mental wellbeing and distress is necessary. This impacts on detention and treatment under the act. The core reported and observable difficulties that lead to detention under the act are psychological and behavioural, and the act, and the focus of treatment directed under it, needs to reflect this reality.

Part of the therapeutic benefit may be a period of assessment, which may mean the benefits are not obvious to the individual, especially when there are concerns around awareness of risk of harm to self or others. We accept that there will always be cases where detention is for reasons of safety and risk management (to the person or others) rather than being obviously therapeutic, but given that even in such cases the long term implications of all detention decisions should be therapeutic, in that they must support the person's access to the time and treatment necessary for recovery.

The difference between treatment and therapeutic benefit is not always clear. There need to be clear links between the understanding of 'mental disorder' for an individual and the treatments and interventions offered to promote 'therapeutic benefit'. The clinical rationale and evidence base for those interventions and treatments should be clear to ensure they could reasonably be expected to produce therapeutic benefit.

Access to psychological, occupational and social therapeutic approaches in the community and inpatient services is essential for choice and therapeutic benefit.

Information should be shared with the detained person and carer about the *personal/individualised* therapeutic benefit and how to challenge detention.

Social issues e.g. around accommodation, and basic needs should be addressed through other legislation, improvements in social equality and access to adequate community based provision.

## Concerns:

The principles of choice, autonomy, and least restriction may create greater risk holding by those with clinical responsibility for patients in community settings. Community professionals often due to lack of resources and integration across health, (education for children) and social care are unable to provide safe, adequate and appropriate care and treatment. Their holding of risk also places them in professional, legal and emotional risk where serious incidents occur. Legally mandatory investigations are sometimes 'blame focused' with professionals often targeted in order to reduce or distract from organisational or systemic shortcomings or culpability. It is important that detention does not occur because these circumstances prevail.

Where individuals refuse available treatment, this could lead to a situation where they can be discharged on the grounds of 'no therapeutic benefit' while still posing a significant risk to themselves or others.

People who have experienced complex trauma or those who have the label of 'personality disorder', where admission is seen as 'non-therapeutic', could be excluded from emergency/acute service provision under the act when appropriate crisis support is needed.

### **Q3. Safety of other persons criterion**

93% agreed or strongly agreed with the change in criteria so that a person is only detained if there is a 'substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person'.

There needs to be clear definition of 'substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person'. The onus must be on the RC to provide examples and evidence.

The only grounds for detention should be that there is risk of imminent harm and the person's capacity/decision-making is impaired to the extent that they are unable to make the decision, returning autonomy and control as soon as the individual has capacity.

It may be more effective to consider the removal of the 'nature' criterion from civil sections, which would bring treatment more in line with physical health (i.e. the degree of problem brings people in to treatment, but people retain choice about longer term care).

There is also an issue around power, the need for collaboration to be demonstrated and who decides on whether the criteria are met. This would exclude people being detained due to refusing a particular form of treatment. The focus should be on enabling people to be active participants in their own recovery unless there is strong evidence that this will lead to

imminent harm. Clinicians should receive training on the impact of stereotypes and cognitive biases on human decision-making in order to ensure that all detention is activated on clinical grounds alone and not influenced by other factors such as unconscious bias.

Sometimes it is difficult to judge the likelihood of harm until there has been opportunity to interact with the person for a while. Sometimes people need a brief admission to reassure them that help is available when needed. Moving people through the pathway efficiently is as important as getting the admission criteria right.

## Chapter 3 Increasing patients' rights to challenge detention

### **Q4. (4.1. – 4.4.) Changes to the timetable for automatic referrals to the Mental Health Tribunal**

97% agreed or strongly agreed with the proposed timetable for automatic referrals to the Mental Health Tribunal for Patients on a section 3

96% agreed or strongly agreed with the proposed timetable for automatic referrals to the Mental Health Tribunal for patients on a community treatment order (CTO)

96% agreed or strongly agreed with the proposed timetable for automatic referrals to the Mental Health Tribunal for patients subject to part 3

93% agreed or strongly agreed with the proposed timetable for automatic referrals to the Mental Health Tribunal patients on a conditional discharge

We agree with all the changes proposed to ensure more frequent review of a patient's case for detention. People's right to challenge and swift access to justice is part of protecting their human rights in this instance and therefore of value here.

Currently, section three requires 6-month reviews of detention. This can result in people experiencing detention for longer than necessary. We propose this is reduced 4 months.

Supporting the patient and their family to understand the process is key; when an individual is in acute distress, they cannot put their points across effectively. Good access to advocacy is essential.

*Concerns:*

Funding is required to mitigate the impact on clinician and administration time if proposed automatic referrals result in an increase in the number of tribunals. Increased demand may impact on treatment provision for



detained and informal patients. Without this, people may be discharged to avoid additional workload.

### **Changes to the authority of tribunals**

#### **Q5. Removal of the automatic referral to a Tribunal received by service users when their Community Treatment Order is revoked.**

43% agreed or strongly agreed with the proposal to remove the automatic referral to a tribunal received by service users when their community treatment order is revoked. 37% were unsure.

A CTO can only apply if person meets the criteria for detention – the justification needs to be clear. The current automatic referral is a necessary safeguard. The decision to discharge from a CTO should be made between the patient and their treating team.

No restrictions should be included in the CTO that cannot be enforced. The inclusion of restrictions that cannot be enforced gives them a false authority.

#### **Q6. Increasing the Mental Health Tribunal's power to grant leave, transfers and community services.**

60% agreed or strongly agreed, 17% disagreed or strongly disagreed and 10% were unsure about the proposal to give the Mental Health Tribunal more power to grant leave, transfers and community services, including the proposal that health and local authorities should be given 5 weeks to deliver on directions made by the Mental Health Tribunal.

The proposal to allow the tribunal to direct leave, transfer and community services via a replacement to section 72 is positive. However, there is a risk that alongside the new proposals' focus on 'treatment benefit', unless the specific treatment availability within community services is also prescribed, via strong governance over the detail of s117 aftercare, patients with complex needs transferred from hospital settings may be transferred to community services where treatment availability is comparatively impoverished. It would be advisable for changes to the act to assert the need for ongoing (specific) treatment availability, rather than purely for the removal of detention.

#### **Q7. Health and Local Authorities should be given five weeks to deliver on directions made by the Mental Health Tribunal.**

The 5-week timescale is not realistic for NHS or local authority clinicians or services to deliver within. Realistic time frames based on availability of local services should be considered at the tribunal. There is particular concern about the ability of appropriate services to be found for individuals with complex needs, where bespoke packages of care are required and staff



may need to be recruited. Clinical judgement is required to ensure managed person-centred transition plans and bespoke staff training.

The authority of the tribunal - where for example a person requires transfer to a forensic bed with a potentially extensive waiting list, no new bed can be commissioned and prepared in 5 weeks and will therefore not be available.

The responsibility of the tribunal for care when giving instructions on leave that contradict the RC's and team's assessment for example, needs to be clear. What responsibility does the tribunal take when it is still the RC who has to authorise this? What if the clinical team continue to disagree?

Commissioners and local services require adequate funding to offer the services required. It is reasonable to give providers some time to make adjustments if they are not able to put suitable arrangements in place, but this should not become a reason for ongoing detention.

### **Proposal to remove the role of the managers' panel in reviewing a patient's case for discharge from detention or a community treatment order**

53%, agreed or strongly agreed, 10% disagreed or strongly disagreed, and 37% were unsure about the proposal to remove the role of the managers' panel in reviewing a patient's case for discharge from detention or a community treatment order.

Many respondents said they didn't have sufficient knowledge to comment.

The main view was that decisions should as much as possible be a collaborative process with the individual, their family and the team that have been working most closely with them. Concerns were that decisions about people's welfare could be made around whether services are there or not rather than being person-centred.

## **Chapter 4: Strengthening the patient's right to choose and refuse treatment**

### **Q8 Advance Choice Documents – what should be included**

There should be a requirement upon detention under the Act, to ask if the person has an Advance Choice Document, and to enable the production of one during a period of detention when the person regains capacity.

There should be a duty on clinicians implementing the MHA to adhere to Advance Choice Documents, or to deviate from them only under specified circumstances which should be clearly recorded. This may be incorporated within the duty to develop a 'clinically appropriate' care plan incorporating 'all relevant factors'.

People should be able to express preferences about treatments they want or do not want to have e.g. certain classes of medication, methods of administration, ECT, psychological and social interventions; preference of profession of lead clinician/AC/RC; people they want informed about the admission; people who they want included in their care meetings or do not want information shared with; their nominated person; a list of things that have been found to be helpful when in distress/crisis. Also, circumstances in which they would want to discontinue particular treatments. Social care needs should be specified in the care plan.

Where the person wishes, co-production of a psychologically informed formulation of their difficulties should be facilitated to inform the care plan. This should be offered sensitively by a suitably qualified and clinically supervised staff member of the person's choosing.

We believe that ECT, psychosurgery and other such procedures should be prohibited for persons not able to give informed consent. Given the nature of these procedures, we recommend that such treatments should be subject to the ratification of a Tribunal even if the patients are able to give informed consent and that clear demonstration that all other evidence-based interventions have been tried and failed should be required.

Also included must be the person's preferences for the inclusion of debriefing following any incidents where any form of restrictive intervention is used. This is particularly important for people with specific expressive and receptive communication needs.

**Q9. The validity of an Advance Choice Document should depend on whether the statements made in the document were made with capacity and apply to the treatment in question, as is the case under the Mental Capacity Act**

79% agree or agree strongly that the validity of an Advance Choice Document should depend on whether the statements made in the document were made with capacity and apply to the treatment in question.

As with any advance legal statements or plans, it is necessary to ascertain that the individual has the capacity to make such decisions about their own care at the time they are made in order to protect that person's interests and wellbeing. The principles within the Mental Capacity Act provide a helpful framework for assessment of capacity in relation to mental health care choices. It may be more helpful to assume capacity, unless there is a reason to suspect that this is not present.

It is important when people are making choices they are not unduly influenced. The choices they make need to be right for them. Evidence should be required that appropriate efforts have been made to facilitate

consensual engagement with treatment and that any communication needs have been recognised and met.

A timescale should be set for regular review of advance choice documents with the person, in case their preferences or circumstances change.

Particular guidance should be implemented to accommodate for the advance choice decisions of people where those decisions, made while the person has capacity to make them, may result in death or serious harm. Such cases should always result in referral to the tribunal before clinicians implement them and clinicians may need legal protection to refuse to carry out such decisions if they feel that they may result in moral injury or potential future litigation or professional sanction.

### **Making Care and Treatment Plans statutory**

#### **Q10. Do you have any other suggestions for what should be included in a person's care and treatment plans?**

Having care plans signed off by the medical or clinical director by day 14 brings in increased and excessive workload on senior managers. There are few senior multidisciplinary staff in such roles and this may perpetuate a bias towards medically dominated and orientated care plans rather than support the diversity in treatment approaches and construal of psychological health that characterise modern mental health practice. Also, if the clinical director is not a medical practitioner as is now increasingly the case in services, this would not allow oversight of the medical component of care plans. We consider that the governance function of this change could be achieved by ensuring that care plans are signed off by a senior clinician of consultant grade from the RC's discipline as well as an Approved Clinician from an additional discipline, covering both the psychological and pharmacological aspects of treatment in the care plan. This would align this change with the multidisciplinary consultation requirements of the existing Act re medical treatment under Section 58.

We believe that the proposed treatments should be of proven efficacy, based on currently accepted professional practice guidelines (e.g. the British National Formulary in respect to medication and guidelines from the National Institute for Health and Care Excellence) and for the therapeutic benefits to outweigh the likely cost to the individual. We also believe that the MHA should require clinicians to provide written reasons for their actions (including their decisions not to do certain things).

Social care needs and commissioning requirements should also be included for people with complex mental health problems. A system equivalent to Care and Treatment Reviews should be considered for people whose mental health impacts on their ability to manage independently in the community.

Working collaboratively with the person's network of support when they have a learning disability or are unable to put forward their wishes to support their care plan is essential. Also, engagement of Speech and Language Therapy to ensure appropriate support for communication needs should also be included.

### **Framework for patient consent and refusal of treatment**

SOADs are medical practitioners. This perpetuates a medical focus to mental health treatment. The role should be broadened in relation to the 'therapeutic benefit' of treatment, with appropriate training to other suitably qualified practitioners e.g. Approved Clinicians from other professional disciplines. This would be particularly important to oversee capacity and consent issues in admissions where admission for psychological treatment is one of the reasons for detention, and detention has proceeded on the basis of the availability of such treatment. At the moment there is no additional governance oversight of these forms of treatment, yet misapplied they can still cause harm. The absence of this governance also perpetuates the view of psychological treatments as supplementary, whereas for many people detained under the Act they are either the principal therapeutic intervention or of equal significance to traditional medical intervention, particularly within the forensic mental health system. The ongoing subsuming of psychological treatment in the Act as 'medical treatment' for the purposes of detention further perpetuates this diminution of the clinical value of psychological approaches to the treatment of psychological distress. We would advise that the wording of the Act is changed so that detention should only happen if 'appropriate medical or psychological treatment is available'.

### **Q11. Patients with capacity who are refusing treatment should have the right to have their wishes respected even if the treatment is considered immediately necessary to alleviate serious suffering**

69% agreed or strongly agreed, 3% disagreed, 28% weren't sure.

This proposal requires a detailed perspective from ethics experts.

We should be working collaboratively with people wherever possible. This may mean that decisions take longer to reach, but the process of reaching it can have a therapeutic impact. Imposing a decision can have serious longer term psychological or re-traumatising consequences.

People who have capacity to make their own informed decisions should be allowed to do so as per the MCA. They have the right to make decisions that others may consider to be unwise. Where possible, decisions should be made with the support of friends, family or other staff as detailed in the advance directive. The capacity of the person in relation to the treatment requires assessment at that point in time. Experience of acute emotional and psychological suffering impacts on decision making, particularly in the

context of the psychological impact of trauma for example to feel deserving of care, have hope that things can change. Teams often 'hold onto hope' for the person experiencing extreme psychological suffering until they are able to feel more hopeful again. The critical issue is the duration of time that should reasonably elapse before someone with capacity as defined in the MCA may be allowed to harm themselves or cause their own death for reasons of psychological preference. There is a fundamental ethical issue regarding the extent that the state can reasonably interfere with the individual's autonomy to decide on whether they wish to continue to live or not, that must be adequately addressed by the new Act. There are significant issues in relation to risk management, for example intervening with self-harm and the intersection with the right to life.

More research and detailed consideration is required and this should then be reflected in better training for clinicians (including clinical psychologists) on the determination of capacity in mental health contexts.

Consideration needs to be given to the psychological and emotional impact on clinicians who may feel morally compromised, independent of statutory requirements, if they are not able to provide treatment to alleviate serious suffering or death.

Some treatments might be considered necessary 'to alleviate serious suffering' but where the evidence for this is at best equivocal and where others with less power (e.g. other team members, patients) might disagree, for example 'emergency' ECT. It is not clear if this proposal would safeguard against this.

**Q12. In addition to the power to require the Responsible Clinician to reconsider treatment decisions, a the Mental Health Tribunal judge (sitting alone) should also be able to order that a specific treatment is not given**

45% agree or strongly agree, 27.5% disagreed, 27.5% were unsure.

The availability of a judge sitting alone to review decisions is similar to existing provisions for serious medical treatment within the Court of Protection for those where capacity is contested or where the judgement is finely balanced. It harmonises rights between people receiving treatment for mental disorder and those with physical illness.

It could be beneficial in terms of requiring the RC to justify the decision to deliver specific treatments that may not be demonstrating effectiveness.

*Concerns:*

This authority takes the decision away from collaborative decision-making between the patient, RC, team and family. Arguably this is less person-centred.

The mental health professional or team would then be required to provide an intervention that they professionally disagree with, feel is unhelpful or risky and have clinical responsibility for.

It is not clear that all individual tribunal judges would have sufficient knowledge of the evidence base on medical and psychological interventions, and legal expertise to understand the full implications of ordering that a specific treatment not be given. Additional training for legal professionals may be required before they can take on this role.

The proposal would need to be adequately resourced to avoid increasing delays around care and treatment decisions.

## Chapter 5: Improving support for people who are detained.

We agree with the new statutory role, known as the 'nominated person', broadening choice of who a patient wants involved in their care and treatment in advance or at the point of detention under the MHA.

The more the person's natural supporters and surrounding community are involved in decisions around care and treatment, where this is acceptable to the person, the better, and strengthening this role will do much to ensure that the individual's wishes are respected.

### **Additional powers of the Nominated Person**

#### **Q13. Do you agree or disagree with the proposed additional powers of the nominated person**

97% agree or strongly agree with the proposed additional powers of the nominated person

This should act as a significant safeguard for the person, if they are unable to advocate for their decisions and preferences. It means people may be able to identify someone confident enough to challenge highly trained professionals, when family members may not feel able to. It is preferable if the nominated person knows the patient well.

The right of the nominated person to be involved in treatment decisions and transfers between hospitals, as well as about renewals and extensions of detentions and CTOs, should be extended, and to include to appeal treatment decisions and object to the use of a CTO on behalf of the patient.

Concerns:

Safeguards for individuals who do not have capacity to nominate a person, or where the person they want is unavailable or refuses e.g. more than one nominated person

Safeguards to ensure that the person nominated has the best interests of the patient at heart; consideration to the risks of abuse of power for personal gains or nominated persons not in the best interests of the patient

**Q14. Do you agree or disagree that someone under the age of 16 should be able to choose a nominated person (including someone who does not have parental responsibility for them), where they have the ability to understand the decision (known as 'Gillick competence')?**

93% agree with the proposal

It is accepted that children under the age of 16 who are 'Gillick competent' have their views considered regarding their physical health. There is a strong argument this needs to be extended to mental health as well.

This is of significant value to children under the age of 16, for example where a parent who has not looked after their best interests may have a say about their care during an acute mental health crisis.

Concerns:

There should be a framework relating to the nominated person to ensure safeguards against the individual nominated not acting in their best interests e.g. where an individual may be abusive, or coercive in the relationship with the young person.

A high proportion of children within the criminal justice system may struggle to identify a suitable person to act as a responsible nominated person.

## **Advocacy**

**Q15. 97% agree or strongly agree with the expansion of the role of the advocate.**

IMHAs play a valuable role, which could be developed and enhanced. IMHAs can help the system understand people's mores and their culture, to advocate for more culturally informed decisions. It is essential advocates are also given to those in forensic services and children's services.

Access to advocacy is a significant issue at present as there are not enough available and often they cannot respond in a timely way. Clear funding needs to be identified for this in practice.



**Q16. Do you agree or disagree that advocacy services could be improved by enhanced standards, regulation, accreditation, or other means**

86% (agreed or strongly agreed) that advocacy services could be improved by enhanced standards, 86% by regulation, 76% by accreditation

This is an important and complex role, where IMHAs are having to function in an emotionally charged situation, within a complex system, where there are power dynamics at play. Supervision, training, and standards could all enable them to function more effectively on behalf of the detained person.

Concerns:

If accreditation or regulation is brought in there may be fewer individuals who have been evidenced to meet the required standards. Any costs associated with individuals becoming regulated/accredited need to be considered - for example if individuals have to self-fund courses/training/exams/assessments - as this could lead to a reduction in the diversity of individuals who are able to achieve the relevant qualifications. The above issues could also lead to a gap in the service and poorer access to advocacy.

**Advocacy curriculum**

The proposed enhanced advocacy curriculum should be produced by a diverse group of individuals and organisations including relevant service user groups, professional bodies and carer representatives from all service areas in mental health. Any failure of diversity could lead to the domination of certain perspectives over others.

Chapter 6. Community Treatment Orders

Deliberately blank

Chapter 7: The interface between the Mental Health Act and the Mental Capacity Act

**Q17 How should the legal framework define the dividing line between the Mental Health Act and the Mental Capacity Act so that patients may be made subject to the powers which most appropriately meet their circumstances?**

Detention should be on grounds of risk and capacity, not whether people are considered to have a 'mental disorder' within a diagnostic framework, with the principle of returning autonomy when capacity is evident.

Detention should be decided principally on grounds of capacity and risk, with the principle of returning autonomy when capacity is evident in the areas of decision-making related to the risks managed by detention. There

should be a statutorily defined range of qualifiers that clinicians can use to determine whether the person requires treatment under detention. We would advise that the descriptors are based around the areas of cognition, affect, and behaviour with a requirement for clinicians to define likely precipitants of the mental state triggering detention; this may involve psychological, social and biological factors. Such a framework is preferable to detaining on the grounds of diagnosis and presentation, given the variability of presentation within the same diagnosis, and the variability in reliability and validity of different diagnostic categories.

The ongoing presence of two legal frameworks to support those lacking capacity to decide on treatment options remains problematic, particularly in the context of an increased focus on human rights-based care. It may be useful to formally elevate the requirements of the MCA above those of the MHA, since, given the HRA is prime, arguably breaches of the rights-based focus of the MCA logically necessitate the unlawfulness of some decisions made under the MHA (for instance, the right to freedom from degrading treatment would be breached if a detained patient with capacity to make a decision about medication was restrained to enforce medication compliance). However, we are aware of the complexity of this situation and of the fact that there may not be a wholly satisfactory solution in law.

**Q18 The right to give advance consent to informal admission to a mental health hospital should be set out in the Mental Health Act (MHA) and the MHA code of practice to make clear the availability of this right to individuals**

The principle of capacity to agree to admission would be key in the event of admission: without this, if an individual had given prior consent and they later become unwell and lost the relevant capacity, then they would be admitted as informal or voluntary patients, as opposed to being detained under the MHA or subject to the Deprivation of Liberty Safeguards (DoLs) or Liberty Protection Safeguards (LPS). This may mean that an individual has less rights than they have under the MHA or MCA e.g. for review of their care if they are admitted to hospital

**Emergency Powers in the MCA and MHA**

**Q19. We want to ensure that health professionals are able to temporarily hold individuals in A&E when they are in crisis and need a mental health assessment, but are trying to leave A&E.**

**Do you think that the amendments to section 4B of the Mental Capacity Act achieve this objective, or should we also extend section 5 of the Mental Health Act (MHA)?**

**Section 4b / Section 5**

75% agreed to the extension of section 5 of the MHA so that it also applies to A&E, accepting that section 4B is still available and can be used where appropriate. 25% were unsure.

There is an assumption that the best place to assess is in A&E. Access to a range of crisis support resources and settings such as crisis cafes and crisis houses is essential. Assessment in less medicalised environments may enable distress and risk to settle, supporting engagement to manage the crisis.

In practice, these departments may still rely on the police to prevent a person from leaving and these services are (rightly) not set up to detain individuals. It may be neither of these tools would change these circumstances. Given that capacity is unlikely to be properly assessed, it should be in both acts.

Difficulties with section 4b become particularly apparent in A&E when supporting people with fluctuating capacity, or those whose lack of capacity is perhaps unclear to non-specialist clinicians. Practical examples include individuals with severe eating disorder-related risk and individuals with intentional self-harm requiring potentially life-preserving treatment (e.g. paracetamol overdose antidote). Existing arrangements risk clinicians allowing harm to come about to individuals who, upon examination would lack capacity to absent themselves from treatment, particularly in borderline cases where the risk of harm is not imminent in minutes but is imminent in terms of hours or days. The expansion of section 5 is therefore supported – however as a safeguard its use in A&E should, in line with its use in mental health settings, be restricted to the professional groups who are Approved Clinicians. This would require A&E to secure the opinion of a registered mental health clinician within a reasonable time frame. Therefore, the operational logistics of this change need careful consideration and prescription in order that rights are preserved.

## Chapter 8 Caring for patients in the criminal justice system

Secure transfer to ensure that people who need care and treatment under the MHA are not being held in prisons or immigration and removal centres (IRCs) inappropriately by introducing a 28-day time limit.

### **Q20 Are other safeguards needed before we can implement a statutory time limit for secure transfers?**

22% stated yes, 7% no, with the remaining 71% unsure

Individuals requiring mental health treatment are being held in inappropriate settings that may be further contributing to their distress. All efforts should be made to ensure that all individuals have access to a safe environment, and that they are immediately removed from situations in institutions that are causing or prolonging harm (including significant emotional harm). For example, if the environment/context of the Immigration Removal Centre is

resulting in an exacerbation of PTSD symptoms, efforts should be made to reduce exposure to triggers, support access to healthcare support, and follow recommendations (e.g. from registered healthcare professionals) for any reasonable adjustments or safety measures (such as access to a Place of Safety) that should be implemented to begin to alleviate the distress whilst awaiting transfer to hospital.

**Q21 A new designated role is proposed for a person to manage the process of transferring people from prison or an immigration removal centre (IRC) to hospital when they require inpatient treatment for their mental health**

55% agreed with expanding the existing Approved Mental Health Professional (AMHP) role in the community so that they are also responsible for managing prison or IRC transfers. 35% thought it would be better to create a new role within NHS England and Improvement (NHSEI) or across NHSEI and Her Majesty's Prison and Probation Service to manage the prison or IRC transfer process; 10% advocated for an alternative approach.

There could be separate modules so that individuals can become an AMHP (as we know them now), or an AMHP for prisons/IRCs, or both. There would potentially be some overlapping modules and some specialist modules. This could allow flexibility for people with forensic or immigration experience to specialise in prison or IRC transfers, or for existing AMHPs to easily expand their knowledge to complete both roles. There would need to be collaboration with the prison and probation service so that qualified individuals could more easily navigate the processes/procedures/systems within prisons/IRCs.

**Restricted patients**

Restricted patients are patients detained in hospital under Part 3 of the Act who are subject to special controls by the Secretary of State for Justice, due to safety concerns. For restricted patients, the Responsible Clinician must seek the consent of the Secretary of State for Justice to allow the patient leave, or to transfer the patient to another hospital, or to discharge the patient.

**Q22 Conditionally discharged patients are generally supervised in the community by a psychiatrist and a social supervisor. How do you think that the role of social supervisor could be strengthened?**

Monitoring in the community provides a least restrictive option. Many people subject to supervised discharge are stable on medication and for their ongoing recovery and functional reintegration, psychological and social interventions and risk assessment and management activity undertaken by forensic clinical psychologists are important. We would support increased use of forensic clinical psychologists as clinical supervisors for Part 3 patients, along with expansion of the role to other disciplines including specialist forensic mental health nurses and social workers.

The therapeutic role of the Social Supervisor should be strengthened, and they should have smaller caseloads.

**Q23 For restricted patients who are no longer therapeutically benefiting from detention in hospital, but whose risk can only be managed safely in the community with continuous supervision.**

56% agree or strongly agree that it should be possible to discharge these patients into the community with conditions that amount to a deprivation of liberty. 20% disagree, 24% were unsure.

In principle, the least restrictive option should be provided. Supervised Community Discharge can provide appropriate safeguards. Living in the community with appropriate safeguards is generally in the best interests of the patient. Funding and support of community services is required to ensure people under such supervision are given the appropriate mental health and social support, and access to a range of treatment options.

**Q24 Supervised discharge order.**

76% agree that a 'supervised discharge' order for this group of patients should be subject to annual tribunal review.

**What other safeguards could be used?**

There should be scrutiny of the therapeutic programme offered - every effort should be made to locate the individual within the community. Annual review is too infrequent and 6-monthly review would provide the opportunity for amendment of the care and treatment package.

**Do you agree or disagree that this is the best way of enabling these patients to move from hospital into the community?**

The MM Supreme Court judgement has created a population of patients who cannot be discharged without concurrent use of a DoLS authorisation that may have the secondary effect of creating the public protection conditions (i.e. community supervision) that allow discharge. Discharge through the expedient of consequences of capacity legislation, rather than discharge directly enabled by it, is a deeply unsatisfactory solution and changes are clearly required.

The proposed solution for these Part 3 patients is therefore preferable – however, its use may be enabled by a new best interests checklist where the degree to which the patient understands that it is in their best interests not to reoffend may be assessed. This assessment would require the use of substantial clinical and forensic clinical expertise, including for some patients, statutory formal neuropsychological evaluation. This would allow for a distinction to be between those who may lack capacity to decide to

reoffend when unsupervised (in the sense that they may be unable to exert executive control when in certain psychological states) and those who may choose to reoffend regardless. For the latter group of patients the argument may be that the mental health system may not be the most appropriate arm of the state to protect the public since they will likely satisfy the requirement of *mens rea* in any recidivism. It would ensure that an additional safeguard is in place to prevent mental health coercion being used in cases where the existing MAPPA arrangements and powers of agencies in the MAPPA are more appropriate vehicles for public protection. In addition, we support the appropriate use of the existing “mental health treatment requirement” by the courts – if this were appropriately resourced then it may be that appropriate intervention could be provided that would either be used instead of Part 3 or would prevent the person’s offending escalating to the point that an offence requiring a Part 3 disposal is committed.

## Chapter 9: people with a learning disability and autistic people

Our proposal is to allow for the detention of people with a learning disability and autistic people for assessment, under Section 2 of the act, when their behaviour is so distressing that there is a substantial risk of significant harm to the person or to other people (as for all detentions) and a probable mental health cause for that behaviour that warrants assessment in hospital. Where the driver of this behaviour is not considered to be a mental health condition, for example, due to an unmet support need, an unmet social or emotional need, or an unmet physical health need (including untreated pain), grounds for a detention under the MHA would no longer be justified and the detention should cease.

### **Q25 Do you agree or disagree with the proposed reforms to the way the Mental Health Act applies to people with a learning disability and autistic people**

72% agree or strongly agree with the proposed reforms to the way the Mental Health Act applies to people with a learning disability and autistic people. 12% disagree, 16% were unsure.

The Act is not going far enough to acknowledge that behaviour, mental health difficulties and distress are very often a product of social inequality, unmet support needs, unmet social or emotional needs, or unmet physical health needs - not only for individuals with a learning disability or autistic people. With this change to the Act in mind, there needs to be improved provisions within the community for individuals who are experiencing significant distress (which may be resulting in behaviours which can cause harm to themselves and/or others). Carers often do not have a basic understanding of behavioural theory, there isn't sufficient access to accredited behaviour specialists, or Speech and Language Therapists, there aren't sufficient respite opportunities, there isn't sufficient funding for



necessary care hours (thresholds for approving funded hours are not appropriately placed), and there need to be more accessible social and employment opportunities.

The removal of learning disability and autism as a mental disorder within the meaning of the Act potentially increases the risk that those with an existing learning disability and autism whose condition deteriorates in degree due to changes in the expression of the condition itself (e.g. due to developmental changes or the interaction between the condition and broad psychosocial variables), will be excluded from the availability of treatment under Section 3, and the safeguards of the MHA, unless a co-occurring mental health condition is diagnosed. This arguably increases the risk of 'diagnostic creep' and the unnecessary medicalisation of psychological distress connected to the primary condition, with for example, additional diagnoses and medications introduced in order to justify detention for reasons of the protection of the person or others.

**Q26 Do you agree or disagree that the proposed reforms provide adequate safeguards for people with a learning disability and autistic people when they do not have a co-occurring mental health condition?**

32% agree or strongly agree that the proposed reforms provide adequate safeguards for people with a learning disability and autistic people when they do not have a co-occurring mental health condition. 24% disagree or strongly disagree, 44% were unsure.

The safeguards for those who do not have a co-occurring "mental health condition" are insufficient. The change proposed will lead to an increase in detention in people with a learning disability and autistic people. There needs to be a focus on the principle of capacity to make decisions and clear justification for overriding autonomy in relation to mental health.

Where there is no co-occurring mental health condition triggering the MHA assessment the unmet social and care needs should be subject to urgent assessment of needs and an appropriate intervention and care package put in place.

For those with learning disabilities and autism, additional review procedures must be ensured and it would be essential for those with additional needs to have a nominated person with them at the time of any assessments, sectioning or reviews.

**Q27 Do you expect that there would be unintended consequences (negative or positive) of the proposals to reform the way the Mental Health Act applies to people with a learning disability and autistic people?**



42% said yes, there would be unintended consequences (negative or positive) of the proposals to reform the way the Mental Health Act applies to people with a learning disability and autistic people, 4% no, 54% unsure.

The proposed changes pose a significant risk of increased use of inappropriately applied diagnosis in people learning disability and autistic people, and increased use of medication to justify detention.

**Q28 We think that the proposal to change the way that the Mental Health Act applies to people with a learning disability and autistic people should only affect civil patients and not those in the criminal justice system. Do you agree or disagree?**

### **Civil vs Criminal**

It is thought that the proposal to change the way that the Mental Health Act applies to people with a learning disability and autistic people should only affect civil patients and not those in the criminal justice system. 17% agree, 42% disagree and 41% were unsure.

It is unsatisfactory to retain learning disability and autism as a mental disorder when making Part 3 decisions but not decisions under Part 4. People with LD/ASD should have the same rights in the civil and criminal systems. They should be offered an opportunity to have suitable treatment and interventions.

If the availability of Part 4 for those conditions alone is removed, a solution may be to focus on *mens rea* (the mental element of a person's intention to commit a crime; or knowledge that one's action or lack of action would cause a crime to be committed) as the criterion for the availability of the MHA for those patients, rather than the diagnosis of learning disability / autism.

**Q29 Do you expect that there would be unintended consequences (negative or positive) on the criminal justice system as a result of our proposals to reform the way the Mental Health Act applies to people with a learning disability and to autistic people?**

For more vulnerable people with learning disability and autistic people at risk of continuing criminal activity, harming self or others due to lack of support, specialist services, monitoring or other safety nets in the community should be in place. The application of the principles of the MCA should underpin any procedure to prosecute.

**Q30 Do you agree or disagree that the proposal that recommendations of a care and treatment review (CTR) for a detained adult or of a care, education and treatment review (CETR) for a detained child should be formally incorporated into a care and treatment plan and responsible clinicians**

**required to explain if recommendations aren't taken forward, will achieve the intended increase compliance with recommendations of a CETR?**

65% agree or strongly agree recommendations of a care and treatment review (CTR) for a detained adult or of a care, education and treatment review (CETR) for a detained child should be formally incorporated into a care and treatment plan and Responsible Clinicians required to explain if recommendations aren't taken forward, and that this will increase compliance with recommendations of a CETR. 35% were unsure.

However, area and service limitations as a result of underfunding and under-resourcing need to be considered.

**Q31 We propose to create a new duty on local commissioners (NHS and local government) to ensure adequacy of supply of community services for people with a learning disability and autistic people. Do you agree or disagree with this?**

80% agree or strongly agree with the proposal to create a new duty on local commissioners (NHS and local government) to ensure adequacy of supply of community services for people with a learning disability and autistic people. 20% were unsure.

There has been a fundamental injustice, in that adequate community services have not been available to date. Lack of appropriate support and community services is a significant contributing factor to distress and behaviours that challenge. It can seriously impact on the safety of the individual in distress and the people who love and care for them. Overstretched generalist staff are currently expected to provide specialist services to autistic patients (many are not accepted by LD services due to the below 70 IQ eligibility criterion loophole). Models of social care need to change; to stay out of hospital, people need access to highly skilled support, particularly around the appropriate application of positive behavioural support and active support approaches.

The commissioning framework for these placements and the service specification needs to be carefully planned with appropriate expert and service user/carer consultation in place.

**Q32 We propose to supplement this with a further duty on commissioners that every local area should understand and monitor the risk of crisis at an individual-level for people with a learning disability and autistic people in the local population through the creation of a local 'at risk' or 'support' register. Do you agree or disagree with this?**

62.5% agree or strongly agree with the further duty on commissioners that every local area should understand and monitor the risk of crisis at an individual level, for people with a learning disability and autistic people in the

local population, through the creation of a local 'at risk' or 'support' register. 37.5% were unsure.

Experience of this process within local children's services is that the time (and cost of this time) is not proportionate to the benefit. LSH has already incorporated a 'level of concern' measure to support the governance of complex community care, and a register could help gauge unmet need. LSH has already incorporated a 'level of concern' measure to support the governance of complex community care. Tiered definitions within the register of concern that are appropriately and objectively operationalised and evidence-informed need to be developed, in partnership with clinical professions, service users and carers.

Services and legislation should move towards regular positive, strengths-based assessments with enhanced care provision, and better access to meaningful community services, education and employment opportunities. Monitoring could constitute a violation of privacy, and interfere with an individual's ability to lead optimally independent lives. Currently there are 'perverse incentives' to keep people in health care settings due to the inadequate funding of community options.

Commissioners need to take more responsibility for their commissioning decisions. At present the burden of responsibility is on underfunded clinical services and practitioners who have little or no say in the way services are structured or regarding the interventions agreed on their behalf

**Q33 What can be done to overcome any challenges around the use of pooled budgets and reporting on spend on services for people with a learning disability and autistic people?**

Housing, social services, health, employment and education would need to have a common budget and competition which drives down quality and wastes time and resources in competitive tendering removed. There also need to be legal and financial consequences for organisations who underbid in order to win contracts and then are incapable of providing services they have agreed to.

Partnership working with the people who are affected by the changes is essential, including co-production with autistic / learning disability advocates.

Agreed outcome measurement tools to allow for a relationship between spend and both clinical and quality of life outcomes to be evaluated are critical if there is to be sound use of public funds. These measures should be centrally prescribed and should involve input from service users and carers, NICE and clinician professional bodies.

## Chapter 10: children and young people

Deliberately blank

## Chapter 11: the experiences of ethnic minority communities

Despite the recent Sewell Report (2021) claiming that British Society is not institutionally racist, in October 2017, former Prime Minister Theresa May announced a review of the Mental Health Act 1983 with the specific intention of addressing the rising rates of detention and the disproportionate numbers of Black, Asian and Minority Ethnic (BAME) people detained and placed on community treatment orders. The subsequent review – Modernising the Mental Health Act (Gov.uk, 2018) confirmed these findings.

It is well evidenced that many people from minority ethnic groups experience trauma that contributes to mental distress, and the way in which the current MHA is implemented can also cause trauma to individuals and their family, carers, friends and supporters. Jacqui Dyer, Ministerial Advisor and Mental health Campaigner (2019) points out that people from minority communities do not have the same experience of mental health services and therefore do not have the same outcomes. It is also well known that the experience of mental distress is influenced by a number of intersecting factors including discrimination, social class and all protected characteristics under the Equality Act (2010) for example see Chapter 6 Intersectionality and Mental Health, Racial Disparities in Mental Health Report (Race Equality Foundation, 2019). We agree with the Race Equality Foundation, who argue that the evidence indicates that the causes of many of the inequalities experienced by marginalised groups and communities are outside of the mental health system, that action is required on the wider determinants of health in order to further reduce those disparities. However, Mental Health Services and the people who work within them are not separate from wider society and will operate in ways that mirror wider inequalities and inequities unless this is specifically paid attention to.

The current focus within secondary care mental health services, where many people who have been detained under the MHA would receive ongoing services, is to be trauma informed. This understanding of trauma and how to resist re-traumatising people within services is in recognition that many people who use mental health services have experienced many, multiple compound traumas. It is important to keep in mind that mental distress may be caused by a number of societal factors and that the appropriate response for an individual may be a legal or social response rather than detention and/or a mental health service. Therefore it is important to have a psychologically informed MHA and psychologically informed services, where all aspects of a person and their multiple contexts are considered equally.

For the reformed MHA to be successful it must provide legislation that is capable of; understanding the mental health, cultural, social and political consequences for minority ethnic groups; respecting diverse cultures and beliefs; promoting equality and equity and promoting an individualised approach. The Patient and Carer Race Equality Framework (PCREF) and culturally appropriate advocacy are both key parts of the White Paper, but the long-term funding for advocacy requires clarification. The PCREF is an excellent example of co-production and a framework for accountability. At present, pilots are being commissioned (Mental Health and Racial Disparities report, 2019). It is essential that all held under the MHA have access to an interpreter if needed, or a cultural advocate, or mental health advocate.

NHS England and NHS Improvement published its first [Advancing Mental Health Equalities Strategy](#) in October 2020, which summarises the core actions the NHS needs to take to bridge the gaps for communities fairing worse than others in mental health services. The strategy sits alongside the [NHS Mental Health Implementation Plan 2019/20 – 2023/24](#), which sets expectations for reducing mental health inequalities in local communities by 2023/24. Those leading integrated care systems (ICS) [have also been required to plan](#) to step up action to address health inequalities as part of their response to COVID-19.

It is ACP-UK's position that the reformed MHA should specifically be assessed against measures that ensure it will be enacted equitably and that this assessment should be conducted by a range of independent partners representing service users and carers, professionals, the Third/Voluntary Sector as well as members of the general public. Convening a Citizen's Assembly to undertake this task and working with organisations such as Citizens UK may be one way to take this forward.

## Part 2

### Reforming policy and practice around the new act to improve patient experience

We welcome the expansion of community services to support adults with severe mental health problems and hope this will enable community-based crisis provision and a decreased need for inpatient care, including under the MHA. Improved access to a range of crisis support options is essential in this. We welcome the focus on therapeutic environments, reducing restrictive practice and improving the quality of ward environments.

#### **The MHA and Fitness to Drive**

This review of the MHA is also an opportunity to consider how other laws disadvantage people with psychiatric diagnoses unfairly. Whilst it is not necessary to have a psychiatric diagnosis to be detained, if a person is diagnosed with severe anxiety or depression, acute psychotic disorder,

hypomania or mania and/or schizophrenia medical practitioners must inform the DVLA and a person's license will be suspended for a minimum of three months. ACP-UK believe the guidelines as they stand are not justified by the scientific evidence base, and furthermore appear to be in breach of the Equalities Act (2010). Capacity to drive should be assessed on a case-by-case basis.

### **Q34 How could the Care Quality Commission support the quality (including safety) of care by extending its monitoring powers?**

The proposals to increase the role of the CQC are welcome and should improve conditions for mental health service users.

The Care Quality Commission should ask about multidisciplinary clinical leadership to ensure person-centred, trauma-informed, holistic care is delivered by all grades of staff. Particular attention should be paid to how collaborative decision-making is promoted, including the whole MDT, the patient and their network of friends and family.

Particular attention should be given to access for patients to psychological interventions by suitably qualified and supervised staff, psychological support for the MDT and psychologically informed environments (both physical and relational). This should include having more psychological professionals as part of CQC inspecting teams. Access to psychological interventions is intrinsic to a high quality, evidence-based service and should be available to all inpatient teams for all rather than a small number of patients.

More unannounced visits and more observation are required.

### **Acknowledgements**

Dr Selma Ebrahim, Consultant Clinical Psychologist, Chair, Complex Mental Health Network, ACP-UK

Professor Peter Kinderman, Liverpool University

Dr Ian Brown, Consultant Clinical Psychologist, Secretary, Complex Mental Health Network, ACP-UK

Paul Sams, Expert by Experience, Complex Mental Health Network Committee Member ACP-UK

Dr Sally Morgan, Director of Media & Communications ACP-UK

Dr Isabel Clarke, Consultant Clinical Psychologist, Committee Member, Complex Mental Health Network, ACP-UK

Dr Ché Rosebert, Director of External Relations, ACP-UK

ACP) UK

ASSOCIATION OF CLINICAL PSYCHOLOGISTS