RadcliffesLeBrasseur

Mental Health Law Think Tank

What should the government consider in the Mental Health Bill?

In 1959, the Mental Health Act was introduced with the intention of moving away from the use of asylums in the direction of less institutionalised mental health care provision. The Mental Health Act of 1983 brought about various changes and again when it was revised in 2007. It appears from the CQC's study of mental health care services published in 2017 that some areas of provision have not changed as much as hoped. Concerns are expressed about the continued use of locked rehabilitation wards and restrictive practices.

The Conservative Party pledged in their manifesto to repeal the Mental Health Act if they were re-elected. The Queen's speech reiterated this intention "My government will reform mental health legislation and ensure that mental health is prioritised in the National Health Service in England".

On 6 July 2017, law firm RadcliffesLeBrasseur held a think tank at its London offices to which it invited health professionals from both the public and private sectors, academics and regulators to discuss what works and what does not work so well under the existing Act and what changes could usefully be included in the Government's proposed Mental Health Bill. This briefing is the result of that discussion.

Executive Summary

Attendees made suggestions for changes in the following areas:

- Searching of inpatients
- Admission and treatment of children
- The role of the Hospital Managers
- Tribunal panel members
- Timeframe for mental health assessment
- The role of the Nearest Relative
- Advocacy
- Aftercare provisions
- Older prisoners with enduring mental illness
- Care planning
- The three month rule
- Detention of patients with capacity
- More emphasis on the Guiding Principles
- The Consent to Treatment provisions
- Restricted patients and the role of the Ministry of Justice
- Deep brain stimulation for specific categories of patient

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Searching

The searching of psychiatric inpatients presents frequent issues for staff who often do not know what is appropriate. Particular difficulties faced by those carrying out searches include not knowing what to do when searching religious garments or cultural and religious artefacts, how to proceed when searching inside underwear, and what to do when a body cavity search is necessary.

The searching of children was noted as more problematic than the searching of adults, often complicated by questions around capacity and/or parental responsibility.

The discrepancy between the searching of informal patients, who cannot be searched without consent and formal patients, who can, was noted. Practical problems result from this situation where informal patients are able to bring items on to the wards for others.

Although searching is already covered by the Mental Health Act Code of Practice, the guidance is, in part, principle based rather than prescriptive and more specific guidance would be welcomed.

One attendee suggested that a "Welcome to the Ward" leaflet should be given to a patient and their family on admission, highlighting searching, amongst other issues. The Bill could include a provision making the giving of such information a requirement.

Children

Of particular difficulty, are situations where a child lacks capacity or has a learning disability.

The interplay with the Deprivation of Liberty Safeguards (DOLS) in this area was also recognised. Currently those with parental responsibility can authorise a DOLS until a child is 16. Thereafter, Court authorisation is required. This was noted as problematic on the front line with attendees concurring that it increased the risk of an unlawful DOLS. Clarity within the Bill would be welcomed.

The transition from child to adult services at 18 needs clarification so that children doing well in child services prior to a move to adult services are better supported.

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Concerns were raised around the inappropriate placement of children with mental health needs, particularly those with complex autism and those placed out of area. Legislation in this area in conjunction with the funding of new beds could alleviate this issue.

The Code of Practice was considered unhelpful in the area of parental authority and there were widespread requests for clarity.

Hospital Managers

A dichotomy of views existed around the role of the Hospital Managers. A number of attendees expressed concerns about the Hospital Managers' involvement. Others argued that they provided a more human approach and were able to understand family dynamics. There was widespread agreement that it is very rare to see an application for a Hospital Managers' hearing from a patient's solicitor. The reason being that it is unlikely to be successful. The Bill could address this.

There was discussion around whether the Hospital Managers should be abolished and by what they could be replaced. Attendees advocated for replacement of the Hospital Managers with a speedier more accessible tribunal. It was suggested that service users should sit on panels and the powers of the tribunal should be extended to enable rulings about other matters such as whether someone should have access to their mobile phone.

The think tank concurred that patients are not always informed of their rights to an independent advocate notwithstanding the existing provisions in the Mental Health Act.

If the Hospital Managers are not abolished, the test they apply should be something other than the "dangerousness test" which was felt to be unhelpful with a distinct lack of clarity around what the test actually means. One contributor to the think tank proposed that the criteria should instead be whether or not the patient is likely to comply with treatment in the community if discharged.

Timescales for assessment

Assessment of mental health under the Act was considered too cumbersome at present and assessments are not undertaken quickly enough. It was proposed tthat part of the reason for this, is under resourcing of community services.

The Nearest Relative

Suggestions were made that it should be easier to displace the Nearest Relative and that patients should be able to choose their own Nearest Relative, thereby bringing the UK into line with Scotland where patients have "named persons" of their choosing. With such a development, it may be necessary to curtail some of the Nearest Relative's powers, for example by raising the threshold for discharge or removing the ability to discharge completely.

Advocacy

The think tank concurred that patients are not always informed of their rights to an independent advocate notwithstanding the existing provisions in the Mental Health Act. The Bill should strengthen the role and implementation of the Independent Mental Health Advocate (IMHA). Provision could be made within the Bill for the right to an independent advocate to become a scheme in respect of which patients need to opt out rather than opt in.

Tribunals

The inability to apply for a Tribunal hearing in the second half of detention under Section 2 was considered to be out of date and not reflective of the fact that a Tribunal hearing could be arranged within a fairly short timeframe. Again, as with Hospital Managers' hearings, the Bill could provide for service users to sit on tribunals. It was suggested that the Bill could include provision for clinicians to be legally represented.

Changes to the First Tier Tribunal

Attendees suggested that revision of the MHA would be an opportune time to bring issues usually destined for the Court of Protection under the remit of the Tribunal. The benefit of this being that matters would be dealt with more cost effectively and quickly.

Community Treatment Orders (CTOs)

A general lack of understanding around CTOs was recognised with problems identified including:

A lack of coercive power, the danger of breaching civil liberties by effectively imposing treatment regimes, there being no obligation to obtain an opinion from the Second Opinion Appointed Doctor (SOAD) prior to discharge, CTOs lapsing and a lack of adherence, the absence of care plans on discharge and difficulties associated with recall such as lack of beds and recall to other hospitals.

The Bill could address when a patient should be discharged from CTO, where those recalled should be recalled to and why a CTO is used.

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Aftercare

Section 117 MHA currently contains the aftercare provisions. Guidance exists but understanding this particular section of the Act continues to be challenging for health care professionals. There are regular disputes on responsibility and there is no guidance on the funding split between health and social care. Attendees concurred that often it depends on where patients live in the country as to how this section of the Act is applied.

One attendee said that research suggests that the majority of people on s117 do not have a care plan on discharge. It was recommended that the Bill should include a duty on health care providers to provide a care plan. The template for this could also be included within the Bill.

Older prisoners

Prisons are not meeting the needs of older prisoners particularly those with dementia or those in need of palliative care. There was support for the introduction of purpose-built secure accommodation as a means of holding older prisoners in a more age-appropriate environment staffed by specially trained employees.

Care Planning

Whilst patients' views should be taken into account, it was recognised that this did not always occur. This could be addressed by the inclusion of a skeleton care plan within the Bill.

Three month rule

Patients detained under section 3 can currently be treated against their will for the first three months. Only after this time are they seen by the Second Opinion Appointed Doctor (SOAD). A shorter timeframe should be included within the Bill to give better protection for these patients.

Detention of patients with capacity

It was proposed the Bill should stipulate that admission without consent should only be considered for those who lack capacity and the Bill could also recognise that those with capacity may decline mental health interventions.

Mental Health Act Principles

The guiding principles of the Act currently contained with the Code of Practice should also be included on the face of the Bill, bringing the Act into line with the Mental Capacity Act.

Consent to Treatment

The current Consent to Treatment provisions should be re-written to make them clearer. The Bill could include provision for capacity assessments to be undertaken and documented in relation to those not consenting.

Ministry of Justice

It was suggested that the Ministry of Justice's role in the Act should be abolished. Concerns were expressed about the current role of the Secretary of State in deciding whether to discharge a restricted patient from hospital.

Treatment

It was proposed that deep brain stimulation used in the treatment of conditions such as OCD and Tourette's syndrome should come under the remit of the Act offering patients with these conditions some protection.

Conclusion

The Conservative government's pledge to repeal the Mental Health Act was positively received by attendees at our think tank with numerous ideas put forward as to what changes could be made. It was clear that those attending held strong views on the subject and much more could be said than the time allowed.

Patients and professionals need a Mental Health Act that better fits the needs of the population, that takes into account issues already recognised by the Conservative Party such as discrimination in mental health treatment and the rising number of detained patients; that facilitates the implementation of the Five Year Forward View published in 2016 and one that includes the points raised by those on the front line of mental health provision.

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