Bar Council response to the Department of Health and Social Care’s consultation paper on Reforming the Mental Health Act

1. This is the response of the General Council of the Bar of England and Wales (the Bar Council) to the third joint consultation paper by the Department of Health and Social Care on Reforming the Mental Health Act.[1]

2. The Bar Council represents approximately 17,000 barristers in England and Wales. It promotes the Bar’s high-quality specialist advocacy and advisory services; fair access to justice for all; the highest standards of ethics, equality and diversity across the profession; and the development of business opportunities for barristers at home and abroad.

3. A strong and independent Bar exists to serve the public and is crucial to the administration of justice. As specialist, independent advocates, barristers enable people to uphold their legal rights and duties, often acting on behalf of the most vulnerable members of society. The Bar makes a vital contribution to the efficient operation of criminal and civil courts. It provides a pool of talented men and women from increasingly diverse backgrounds from which a significant proportion of the judiciary is drawn, on whose independence the Rule of Law and our democratic way of life depend. The Bar Council is the Approved Regulator for the Bar of England and Wales. It discharges its regulatory functions through the independent Bar Standards Board (BSB.)

Introduction:

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[1] Consultation paper

4. We are pleased to have the opportunity to respond to this important consultation ("the White Paper") on the reform of the Mental Health Act (MHA). This is a pivotal piece of legislation which could have an impact on any citizen. It is vital that the MHA or any successor legislation strikes the right balance between the imperatives of the promotion of autonomy and protection from harm.

5. With this in mind we note the findings of the Independent Review of the Mental Health Act, chaired by Professor Sir Simon Wessely, "Modernising the Mental Health Act- Increasing Choice, reducing compulsion"[2]. In his introduction, Sir Simon wrote:

"I was tasked to see If the Act is up to date in how it deals with human rights (it isn't)"

6. We agree with Sir Simon's assessment that there is a need to "shift the dial" in favour of patients.

7. Below, we have included our response to those questions in Part 1 of the White Paper which we feel able to answer. We note that in some chapters the White Paper does not seek responses (for example, Chapter 6 on community treatment orders, "CTOs"). Where we considered this to be appropriate, we have made observations in the hope that these are helpful.

Part 1: Proposals for reform of the Mental Health Act

Question 1: We propose embedding the principles in the MHA and the MHA Code of Practice. Where else would you like to see the principles applied to ensure that they have an impact and are embedded in everyday practice?

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[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf

8. We welcome the Government's stated commitment in Part 3 of the White Paper to include the four principles (choice and autonomy, least restriction, therapeutic benefit and the person as an individual) in the MHA and the MHA Code. This both follows the recommendations of the 2018 Independent Review, and is the analogue of the approach taken to embed the core capacity and best interests principles in the first section of the Mental Capacity Act 2005 (See s.1 MCA). We also agree that each of these principles is crucial to the development of a progressive legislative framework governing mental health care, treatment and detention.

9. We note, of course, that three of the principal concerns identified both in the Independent Review and the White Paper are the recent and remarkable increase in rates of detention; the "profound" inequalities of access, experience and outcomes for people from ethnic minority communities reflected in a disproportionate use of detention and the use of coercive powers in the cases of black people in particular; and the protracted and therapeutically inappropriate detention of many persons with autism, learning disabilities and schizophrenia (See White Paper, p.23). All of the categories of person considered to be badly served by the existing legislation would fall to be protected by domestic (e.g. the Equality Act 2010) and international (e.g. ECHR) anti-discrimination law. Given the deleterious impact of the current regime on these groups, and the absence of any explicit attempts to read-across established principles of equality to the mental health context, we regard it as appropriate for consideration to be given to making anti-discrimination/equality a core principle of the MHA and the MHA Code. It is worth noting that the independent race equality organisations 'Race on the Agenda' ("ROTA") and the ("Race Equality Foundation") made this plea in relation to race equality in their submission to the Review in 2018 (https://www.rota.org.uk/sites/default/files/ROTA_REF%20Submission%20to%20MentalHealth%20Act%20review%20030718.pdf). We consider that this ought to apply to all "protected characteristics" under the Equality Act 2010 ("EA 2010") and merits a careful assessment of the benefit of including a general equality principle, particularly

as neither private law claims under the EA 2010 nor the s. 149 EA 2010 public sector equality duty would provide any or any speedy redress in respect of a challenge to the use of powers under the MHA.

Question 2: We want to change the detention criteria so that detention must provide a therapeutic benefit to the individual. Do you agree or disagree with this proposal?

10. We strongly agree with this proposal.

Question 2a: Please give reasons for your answer

11. "Therapeutic benefit" has long been understood to be the touchstone of modern approaches to psychiatric care (See the evidence given by Professor Nigel Eastman to the Joint Committee on Human Rights in respect of the changes to the MHA made in 2007 extracted in Jones, R Mental Health Act Manual, 23rd Ed, 1-074). However, the possibility of detaining a patient, once the other diagnostic and risk criteria were satisfied, by reference to the *availability* of appropriate treatment (see. S.3(2)(d) MHA) has been considered by many to prioritise risk reduction over and above the restoration or preservation of health. This new proposal, together with the requirement for the relevant clinician to devise a Care and Treatment Plan which identifies precisely what the therapeutic benefit will be, ought to underscore the importance of the recovery, rather than the containment, of those who are subject to the regime.

Question 3: We also want to change the detention criteria so that an individual 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. Do you agree or disagree with this change?

12. We strongly agree with this proposal.

Question 3a: Please give reasons for your answer

13. Our support for this proposed change is consistent with our support for the long term aim to ensure that carceral solutions to psycho-social problems become the exception rather than the rule. The requirement to justify detention by reference to a higher and more exacting risk threshold is likely to reduce detention rates, particularly where augmented by increased, and adequately funded, early intervention and community support provision.

CHAPTER 3- Giving patients more rights to challenge detention

Question 4: Do you agree or disagree with the proposed timetable for automatic referral to the Mental Health Tribunal?

a) Patients on a section 3

14. We agree with these proposals in relation to those detained under section 3. We consider that the automatic referral is a valuable safeguard, particularly for those lacking capacity to apply to the Tribunal. Three years is far too long a period for individuals to wait for an automatic referral.

15. We note that the Government is not seeking responses to the proposed reforms to access to the Tribunal for those detained under section 2. We agree with the extension of time to 21 days from detention for those patients. We note that the Government has not used this opportunity to address the violation of Article 5(4) identified in MH v UK App 11577/06 and make provision for a referral to the Tribunal

for patients detained under section 2 and lacking capacity to apply to the Tribunal. This is regrettable. Those detained under the MHA and lacking capacity to apply to the Tribunal are by definition disadvantaged in terms of their ability to enforce their rights. Moreover we note with disappointment that the recommendation of the Independent Review (to introduce a requirement for a second clinical assessment at 14 days) has not been followed. We consider this to have been a reasonable pragmatic solution to what would have been a significant burden to the Tribunal service, and would have provided an element of independent oversight for some of the most vulnerable patients.

b) Patients on a community treatment order (CTO)

16. We can see the rationale for extending the time at which the CTO patient's case is referred to the Tribunal from 6 months from the date of the detention to 6 months after the CTO. We support these proposals apart from the proposal to remove the automatic referral when a patient's CTO is revoked.

c) Patients subject to Part III

17. We agree with these proposals.

d) Patients on a conditional discharge

18. We support the enhanced safeguards for this group.

Question 5

We want to remove the automatic referral to a tribunal received by service users when their community treatment order is revoked. Do you agree or disagree with this proposal?

19. We disagree with this proposal. This is a significant safeguard, in circumstances where a patient is compulsorily detained without the procedural requirements for sections 2 and 3 (medical recommendations and AMHP application).

20. We note that it is suggested that in some cases after revocation of the CTO, the patient is back on a CTO by the time the Tribunal hearing takes place. If the patient at that stage does not contest the CTO, the tribunal can dispose of the matter on the papers. If the patient is back on a section 3, it is incorrect to say that the referral hearing will have no impact on the patient. The Tribunal will apply the statutory criteria for section 3 and if these are not met then the patient will be discharged.

Question 6

We want to give the Mental Health Tribunal more power to grant leave, transfers and community services.

We propose that health and local authorities should be given 5 weeks to deliver on directions made by the Mental Health Tribunal. Do you agree or disagree that this is an appropriate amount of time?

21. We welcome this proposal which in our view represents a genuine improvement in the rights of patients.

Question 7

Do you agree or disagree with 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?

22. On balance, we agree with this proposal, given the increased access to the Tribunal which accompanies it.

CHAPTER 4: Strengthening the patient's right to choose and refuse treatment.

Question 8

Do you have any other suggestions for what should be included in a person's advance choice document?

23. No, we think that the list suggested is comprehensive. What is important is that expectations are properly managed. A "legal requirement that ACDs are considered when a patient's care and treatment is developed" will be very easily satisfied. It is a big step from such a requirement - welcome as it is - to asserting that the ACD will have "real power and influence". We anticipate that there will be many occasions where it will be genuinely impossible to comply with the preferences expressed. It will depend on the available options at the time.

24. At present, the Code of Practice (24.6) requires decision-makers on treatment to "take account of any advance decisions made by the person and any wishes and feelings they have expressed in advance of treatment". The Consultation paper notes that, under the current law, a patient can express a preference for one anti-psychotic over another. However the paper continues:

while the responsible clinician is professionally obliged to act in the best interests of the patient, they are not legally obliged to take this into account.

25. We are not sure this is correct. The Code does require the RC to take the patient's preference into account; however the patient's clinical best interests would over-ride the preference. In our view the position will be exactly the same under the current proposals. The RC's professional responsibilities will be unchanged and s/he would not be obliged to act against the patient's best interests simply because the patient has an ACD.

26. The process of genuine co-production both of the ACD and, crucially, the treatment plan, would in our view add significant value for patients and their families. This would be regarded as good practice now and is required to comply with the over-arching principle referred to at paragraph 1.1 of the Code of Practice:

“Empowerment and involvement- patients should be fully involved in decisions about care, support and treatment”.

Question 9

Do you agree or disagree 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 is the case under the Mental Capacity Act?

27. A valid advance decision under the MCA 2005 is equivalent to a capacitous refusal of treatment. That treatment cannot then be given, save in certain exceptional circumstances, whatever the consequences to the patient. Its validity is therefore dependent on the capacity of the person making the advance decision. It will only be over-ridden in circumstances where the choice of a capacitous person can also be over-ridden.

28. As we understand it, an ACD is different. It may encompass refusals of certain treatments; it may also encompass preferences and positive requests. A person does not have to have capacity to express a preference. It therefore seems potentially unfair to restrict ACDs to those with capacity to make the specific decisions, especially as it does not appear that they are intended to be determinative. We would wish to consider this point further once the legal status of an ACD has been clarified.

Question 10

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

29. We welcome the commitment to put care and treatment plans on a statutory footing. This seems to be a comprehensive list. It may be beneficial to break some of the sections down further, as is the case in the Code of Practice when it considers care planning at 34.19, specifying mental health care, psychological needs, daytime activities, needs arising from co-existing physical disabilities, etc.

Additional comment:

30. We note that specific response has not been sought to the proposals to amend the provisions for treatment currently delivered under section 58A by requiring the responsible clinician to seek permission from the court to over-ride either a capacitous refusal or a valid ACD in an emergency. We agree in principle that this adds a further important safeguard. Any such application to the court is likely to require urgent and possibly out of hours consideration, which the Tribunal is not able to accommodate. In these circumstances we assume it is suggested that the duty judge of the Family Division would hear such applications. Suitable and sufficient resources need to be available in terms of judicial time and representation for the patient.

Question 11

Do you agree or disagree that 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?

31. We do agree with this proposal, with the safeguards suggested. We are, of course, mindful of the duties under Article 2 ECHR, which could arise if for example a patient's depression caused serious suffering and at the same time created a real and immediate risk that the patient might take their own life.

Question 12

Do you agree or disagree that in addition to the power to require the responsible clinician to reconsider treatment decisions, the Mental Health Tribunal judge (sitting alone) should also be able to order that a specific treatment is not given?

32. This is a very significant change to the current legal position (following the Court of Appeal in Djaba v West London Mental Health Trust [2017] EWCA Civ 436): that the Tribunal has no jurisdiction to hear challenges to treatment decisions. At present these can only be litigated in the Administrative Court, putting such challenges out of the reach of most patients. This is a welcome proposal as we consider judicial review to be a 'blunt instrument' for essentially fact-specific issues. Clearly this will require significant resources for the Tribunal and for representatives, in terms of capacity and skillset, in the absence of which these new rights cannot be made effective. The judge will need to have access to the advice of a medical member in an appropriate case.

CHAPTER 5 Improving the support for people who are detained

33. In broad terms, the replacement of the concept of a statutorily-prescribed nearest relative with a Nominated Person is welcomed. While there is a degree of certainty to the concept of a nearest relative, we agree with the observations of the

review by Sir Simon Wessely[3] that the concept of the nearest relative is "outdated" and that the system of choosing a nearest relative "actually means not being able to choose".[4]

34. The ability to select, at an early stage via the Advance Choice Document, a Nominated Person is central to both key principles of "Choice and Autonomy" and "The Person as an Individual" and, as such, is a reform that is to be welcomed.

Question 13 Do you agree or disagree with the proposed additional powers of the Nominated Person

35. We strongly agree with the additional proposed powers as they are summarised in the White Paper, i.e. (a) to be consulted on statutory Care and Treatment Plans, (b) to be consulted on transfers, renewals and extensions to detention or CTO, (c) to appeal clinical treatment decisions at the Tribunal, (d) to object to the use of a CTO.

36. The involvement of the NP in the preparation of a CTP is consistent with the involvement of advocates, families and carers in the sphere of assessments under the Care Act 2014 (section 9(5)) and of parents in the preparation of Education, Health and Care Plans (section 19, Children and Families Act 2014). Given the analogy drawn in the White Paper with other care planning regimes,[5] we are of the view that drawing from a diverse range of views at the initial stage of preparing a CTP not only promotes the key principles identified in the White Paper but additionally assists in the engagement of stakeholders in the detention itself.

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[3] Modernising the Mental Health Act: Increasing choice, reducing compulsion, December 2018 ("the Report").

[4] We were struck by the example contained in the Wessely Report (page 85) whereby a service user expressed dismay that a sibling would automatically be appointed as nearest relative in the event of incapacity of the sole parent.

[5] Page 39 of the White Paper.

37. Likewise, requiring consultation, rather than mere notification, on transfers, renewals and extensions, is, in our view, consistent with the objectives being promoted by the White Paper.

38. In relation to challenging clinical treatment decisions at Tribunal, we note that this power will vest in the NP only where the patient lacks capacity to bring such a challenge or make such a decision and assume that the power would arise if the NP believes that the patient would not agree to that treatment.[6]

39. We support the use of the Tribunal as an alternative to judicial review: the use of judicial review in this context is not appropriate, it is cumbersome, excessively formal, inaccessible to the majority of NPs, slow and expensive; access to a specialist Tribunal avoids most if not all of those concerns.

40. The White Paper does not specify clearly the scope of the Tribunal's role. We note the proposals set out in the Report[7] that the Tribunal would (i) have power to obtain further clinical evidence, akin to the power under section 49 of the Mental Capacity Act 2005, (ii) that there would be a permission stage, akin to judicial review. We support the proposal to bring the power of the Tribunal in line with that of the Court of Protection.

41. As to the question of a permission stage, while a valuable tool to prevent frivolous or vexatious cases, the question would be the threshold test; the test for permission in judicial review cases (that there is an arguable case that merits full investigation at hearing[8]) is not obviously appropriate in the context. A clearer test

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[6] See p.76 of the Wessley Review.

[7] Page 76

[8] *R v Legal Aid Board, ex p Hughes* [1992] 5 Admin LR 623

would be to adopt the pre-conditions proposed in the Report[9] – i.e. that the second opinion appointed doctor has confirmed that treatment should be given, that the NP has set out reasons for a full hearing and that the application relates to a specific disagreement about an individual treatment decision – this would provide a clear threshold for permission, and clarity for the Tribunal, the health professionals involved and the patient/NR. Such simplicity is, in our view, consistent with the general approach in the White Paper.

42. While there is an argument that the enhancement of the role of the NP is inconsistent with the person-centred approach set out in the key principles, as it places emphasis away from the wishes and feelings of the patient and towards third parties, such a view in our opinion misunderstands the role of the NP to advocate on behalf of the patient and to act with due regard to their welfare. The benefits of an additional safeguard on the regime of detention outweigh any perceived inconsistency.

43. We agree that any enhanced powers should be the subject of detailed guidance. The emphasis must be placed on the need for such guidance to be clear. To that end, any guidance should be formulated through a process of consultation and cooperation with relevant stakeholders.

Question 14 Do you agree that someone under the age of 16 should be able to choose a NP where they have 'Gillick competence".

44. We agree with the proposal that someone under the age of 16 should be able to choose a NP where they have Gillick competence.

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[9] Page 77

45. That conclusion is a natural extension of the view expressed in *Gillick*[10] by Lord Scarman that ""as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed." We also note the observations of Keehan J in *Birmingham City Council v D*[11] (approved by Baroness Hale in the Supreme Court[12]) that not only has the common law acknowledged the concept of an "age of discretion"[13] but also that Parliament has been increasingly willing to emphasise the autonomy to be afforded to those under 16. We also note that the proposal is consistent with the overriding principles of Choice and Autonomy and of treating the Patient as an individual.

46. We are alive to the fact that the Supreme Court in *D* was not clear as to whether the question of parental responsibility could be overridden in respect of those under 16 (contrast Lady Hale [50] with Lady Black [90]) but note that the decision to choose a NP is consistent with the principle in *Gillick* that a person with parental responsibility can lose their exclusive decision-making powers before the child reaches the age of 16. We welcome the express reference in the White Paper to the preservation of "usual rights" of a person with parental responsibility to information and to be consulted about the child's care.

<u>Question 15 – Do you agree with the proposed additional power for Independent Mental Health Advocates?</u>

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[10] *Gillick v North Norfolk and Wisbech Area Health Authority* [1986] AC 112, HL.

[11] [2016] PTSR 1129

[12] [2019] UKSC 42 [2019] P.T.S.R. 1816, at [26]

[13] Summarised by Lord Denning MR in *Hewer v Bryant* [1970] 1 QB 357: ""the legal right of a parent to the custody of a child … is a dwindling right which the courts will hesitate to enforce against the wishes of the child, and the more so the older he is. It starts with a right of control and ends with little more than advice.""

47. We strongly agree with the proposal that IMHAs should have additional safeguarding powers, namely: support during care planning, support in preparing Advance Choice Documents, powers to challenge a particular treatment and power to appeal to the Tribunal on behalf of the patient.

48. Requiring IMHA powers to include the planning and advance choice documents is, in our view, a key part of the shared decision-making which underlines the proposed reforms to how decisions about care and treatment are made.

49. As noted in relation to question 13, empowering an IMHA to have an active role in the planning process and in challenging treatment brings the MHA into line with other care legislation, such as the Care Act, where Care Act Advocates are under a duty to challenge treatment decisions.[14]

50. We note in our comments on Chapter 10 our regret that IMHAs are not to be extended to children and young people who are informal patients.

<u>Question 16 – do you agree that advocacy services could be improved</u>

51. In our view –

a. We agree that advocacy services could be improved by enhanced standards
b. We disagree that advocacy services could be improved by regulation
c. We disagree that advocacy services could be improved by enhanced accreditation;
d. We strongly disagree that advocacy services could be improved by none of the above.

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[14] Reg 5(8), Care and Support (Independent Advocacy Support) Regulations 2014.

52. While there is a need for Advocates to be properly trained and for standards to be maintained, we are conscious that there is a need for increased cultural competency in mental health services,[15] including the provision of advocates who are able to assist in overcoming cultural barriers and understand the needs of the disproportionately represented members of the BAME community. That is achieved through working with communities to ensure that services – including advocacy - and solutions to problems are co-produced. We invite specific note to be taken of our comments in response to question 1 above , and Chapter 11 and question 35 below.

53. We share the concerns of the Report that excessive regulation could be a barrier to the engagement of those from excluded communities, removing accessibility, removing the current informality that promotes bespoke services for those with specific protected characteristics.

54. The aims of the White Paper could, in our view, be better achieved through enhanced standards and specific funding for the improvement/development of the cultural competence of advocates and note that there is already a pilot in train.

55. Where regulation may have a role to play is in holding commissioners to account in the development of advocacy services that meet the needs of diverse communities.

CHAPTER 6-Community Treatment Orders

56. There are no questions here: however we make the following observations in the hope that these are helpful.

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[15] Grey T., Sewell H., Shapiro G. et al. (2013) Mental health inequalities facing U.K. minority ethnic populations. *Journal of Psychological Issues in Organizational Culture,*

57. As the White Paper notes, the over-representation of people of black African or Caribbean heritage is vast and this is extremely troubling, because it strongly suggests disproportionality in the use of coercion. The Final Report of the Independent Review expressed the hope that the overall package of reforms would cut the use of CTOs by half. If the use of CTOs has not been reduced, or if they have not been shown to be effective, within 5 years CTOs should be reviewed again with a view to abolishing them. The report also recommended:

- aligning the criteria with the new detention criteria
- a threshold for demonstrating previous disengagement leading to significant decline in mental health, so that a CTO would only be used after the first admission "in the rarest of circumstances"
- giving the 'nominated person' power to object to a CTO with a requirement for the AMHP to consult them before a CTO is made
- three professionals to be involved in the creation of the CTO so as to involve the supervising clinician
- strengthening the recall criteria
- CTOs to end after 2 years

58. From the proposals in the White Paper it would appear that the requirement to demonstrate previous disengagement from services will not become part of the revised criteria. This is not a positive indication for the prospect of reducing the use of CTOs. This requirement would have ensured that CTOs are used for precisely the individuals they were designed for – the so-called "revolving door patients".

59. We are pleased to note however the proposals as to the involvement of the community RC in the creation of CTOs, as to the ability of the nominated person to object to the CTO. We are also heartened by the government's stated commitment to

reducing their use and to reducing the glaring disparity of their use in respect of members of the black community.

60. We welcome the extension of the Tribunal's statutory powers to make recommendations to include the conditions of CTOs. We however think it is a missed opportunity not to allow the Tribunal the power to discharge or vary conditions. We find it hard to see the logic in allowing the Tribunal to set aside medical treatment decisions but not CTO conditions.

CHAPTER 8: Caring for patients in the criminal justice system

Q20: To speed up the transfer from prison or immigration removal centres (IRCs) to mental health inpatient settings, we want to introduce a 28 day time limit. Do any further safeguards need to be in place before we can implement a statutory time limit for secure transfers?

61. Yes.

Q20a: Please explain your answer.

62. We support the introduction of a statutory time limit.[16] Action is required in order to reduce the lengthy delays that are commonly experienced in the assessment and admission process, and which mean that acutely unwell prisoners wait too long to access appropriate treatment.

63. Perverse incentives pervade the current system. We understand that some clinicians may wait for a bed to become available before 'starting the clock' on the

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[16] In line, for example, with the Joint Committee on Human Rights in their interim report 'Mental Health and Deaths in Prison: Interim Report', Seventh Report of Session 2016-17 (HL Paper 167, HC 893), p.9.

relevant processes. As noted by stakeholders, the introduction of a statutory time limit could inadvertently further entrench such perverse incentives – as is highlighted by the example of clinicians not recommending hospitalisation if they, or their employing authority, consider that they are at risk of being penalised for not meeting the deadline.

64. We consider that the essential safeguards are to be found in addressing the underlying practical problems that cause delay. Most significantly, there continues to be an urgent need for commissioners to rectify bed shortages. There needs to be a clearer understanding (and one that is shared between prison and hospital clinicians) as to when transfer will urgently be needed: further guidance may be required. Streamlined procedures to ensure speedy access of psychiatrists to prisoners will assist. Although a less common issue, further guidance may be helpful in encouraging resolution where there is a difference of opinion between two assessing doctors.

65. We support the introduction of a stronger monitoring system in order to provide information on the functioning of the transfer process, and would also like to see a robust system for ensuring compliance.

Q21: We want to establish a new designated role for a person to manage the process of transferring people from prison or an Immigration Removal Centre to hospital when they require inpatient treatment for their mental health. Which of the following options do you think is the most effective approach to achieving this? (a) Expanding the existing Approved Mental Health Professional (AMHP) role in the community so that they are also responsible for managing prison/IRC transfers; (b) Creating a new role within NHSEI or across NHSEI and HMPPS to manage the prison/IRC transfer process; (c) An alternative approach (please specify).

66. (b) Creating a new role within NHSEI or across NHSEI and HMPPS to manage the prison/IRC transfer process.

Q21a: Please give reasons for your answer.

67. We agree that there is a need for such a role. Whilst AMHPs would in many ways be well suited, it is important to take into account practical considerations on the ground. First, given the existing heavy workload of AMHPs and shortages amongst their number, the introduction of this additional important and likely time-consuming responsibility may cause further problems and/or delays, either in the execution of these new responsibilities or in the context of existing responsibilities. Secondly, we agree that placing the role within NHSEI and HMPPS should allow the responsible person to take advantage of knowledge of how the relevant systems work and how to overcome institutional barriers where they arise. Given the nature of their current responsibilities, AMHPs are unlikely to have this important internal knowledge and experience.

68. We strongly support the proposal that this role take a patient-centric approach. Too often prisoners (and their legal representative, if they have one) are kept in the dark about the processes underway, the timescales and how they might contribute to or influence the assessments and decisions being taken. It is likely that there will be a separate need for advocacy support (as raised at p.72). In any case, we agree that the new role should be executed from a team that is separate to that involved in commissioning or providing beds, and that its "prime responsibility" should be to the needs of 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?

69. As set out in the White Paper, the role of social supervisor is key to an effective conditional discharge process. The balance between supporting a patient's reintegration into the community whilst at the same time policing the patient's condition and behaviour is a delicate one. A social supervisor who has the necessary skills, capacity and resources to build an effective and supportive rapport with a patient will in so doing also contribute towards the objective of protecting the public.

70. As the MoJ and HMPPS guidance for social supervisors (5 July 2019) makes clear, effective social supervision requires considerable expertise and experience. Given the relatively low number of conditionally discharged patients in the community, we appreciate that it can be difficult to build up the necessary institutional expertise and experience. As a result, we consider that specified qualifications and training in the field of forensic mental health and social work should be a precondition to taking on this role. The current position as set out in the guidance – i.e. that it is "strongly recommended that any social supervisor who does not have experience of managing restricted patients should attend one of the Mental Health Casework Section's open days which explain the role of the Ministry of Justice in managing restricted patients" (para. 1) – does not go far enough. Training should be mandatory and ongoing, with regular refreshers; it is almost impossible for all the necessary elements to be covered in one open day. To treat that attendance as sufficient is to seriously under-estimate the complexity and significance of the function. The role must also be effectively supervised by a team leader of the appropriate grade.

71. The current guidance is detailed and helpful but needs to be fully absorbed and applied without regional divergence if it is to be effective. We consider that the guidance could further be strengthened by the inclusion of case studies in order to

provide practical examples, and could potentially also include flow charts and diagrams to provide a summary of the relevant considerations and processes.

Q23: For restricted patients who are no longer therapeutically benefitting from detention in hospital, but whose risk could only be managed safely in the community with continuous supervision, we think it should be possible to discharge these patients into the community with conditions that amount to a deprivation of liberty. Do you agree or disagree that this is the best way of enabling these patients to move from hospital into the community?

72. *Not sure.*

Q23a: Please give reasons for your answer.

73. We agree that patients should not remain in hospital longer than is necessary merely because there is no available suitable legal route out of hospital which allows for the management of risk without a deprivation of liberty. It is also right that action ought to be taken to regularise arrangements currently in place that are unlawful: This was specifically acknowledged in the HMPPS MHCS guidance 'Discharge conditions that amount to deprivation of liberty' (Jan 2019) which states (at s.2, p.2) that "the Secretary of State recognises that there are some patients already living in the community subject to conditions amounting to a deprivation of liberty and, therefore, unlawful conditions".

74. However, the question of whether a 'supervised discharge order' is the best mechanism for achieving this legitimate aim does not afford a straightforward answer. We would be concerned about the potential for the restrictive conditions involved in such orders to become the "new normal" in a culture that is already

increasingly risk averse – a culture that the recommendations of the Independent Review seek to address.

75. We wonder whether there might be advantages to maintaining the status quo - i.e. the "temporary operational solution while legislative change is considered". This has operated so that the Secretary of State will consent to the use of a long-term escorted leave of absence under s.17(3) MHA if it appears appropriate in an individual case and until such time as the patient is ready for arrangements that do not amount to continuous supervision and control (see s.6 of the Jan 2019 guidance). Such a mechanism may provide for greater flexibility and lend itself more naturally to a gradual reduction in the restrictiveness of the arrangements.

76. We recognise, however, that in cases where there is no therapeutic benefit of any kind in continued treatment in hospital the use of extended s.17 leave may not be an appropriate solution: as confirmed in the recent case of *DB v Betsi Cadwaladr University Health Board* [2021] UKUT 53 (AAC), for it to remain "appropriate for [a patient] to be liable to be detained in a hospital for medical treatment" a significant component of her treatment must be in hospital. In that case, the Upper Tribunal held that liability to detention was not a fallback when other options were unsuitable or unavailable and indicated that if the statutory conditions for (liability to) detention are not met, discharge must be directed. Suitability of extended leave in the types of cases envisaged may depend on the nature and extent of contact and treatment that a patient continues to have in hospital (bearing in mind the broad definitions of "hospital" and "treatment" given in *KL v Somerset Partnership NHS Foundation Trust* [2011] UKUT 233 (AAC) and *SL v Ludlow Street Healthcare* [2015] UKUT 398 (AAC) respectively).

77. The use of s.17(3) powers may also be less appropriate in cases where the risks are unlikely to reduce or change, such that in all likelihood constant supervision will

remain necessary in the longer term. Reliance on s.17(3) could also give rise to issues in relation to aftercare arrangements given that the s.117 obligation does not bite until the patient ceases to be detained (though such difficulties should be remediable).

78. In the absence of any information and data as to how the temporary operational solution has been working in practice it is not possible for us at this stage to form a settled view as to whether a 'supervised discharge order' is a necessary legislative change, and one which meets the legitimate aim discussed above in the least restrictive way possible.

Q24: If agree:- We propose that a 'supervised discharge' order for this group of patients would be subject to annual Tribunal review. Do you agree or disagree with the proposed safeguard?

Q25: Beyond this, what further safeguards do you think are required?

79. In relation to questions 24 and 25, we consider that if patients are to be made the subject of a 'supervised discharge order' they should be entitled to the same degree of protection as those deprived of their liberty by existing legal arrangements: see *Secretary of State for Justice v MM* [2018] UKSC 60 at para. 37 per Lady Hale.

CHAPTER 9. People with a learning disability and autistic people

Question 26

Do you agree or disagree with the proposed reforms to the way the MHA applies to people with a learning disability and autistic people?

80. We welcome the commitment to 'reducing reliance on specialist inpatient services for this group, and to developing community alternatives.' A key focus must

remain on preventing the need for any detention, or ensuring that detention is a matter of last resort. The JCHR (2019) proposed a specific narrowing of admission criteria for this group, which included express reference to treatment 'not available in the community and only available in detention (i.e. as the last and only resort)'. We endorse that recommendation. It is our view that the priority must be for the provision of services promoting autonomy and independent living for this group recognising that institutional settings, and medium or long term inpatient admissions, are wholly inappropriate.

81. The IMHAR accepted that being placed in an environment lacking in 'reasonable adjustments' was far from ideal, and there are concerns that professionals delivering care within MHA services do not understand the specific needs of a person with a learning disability, autism or both. We note that the evidence presented to the IMHAR was equivocal with regard to whether or not this group of individuals should be excluded from the MHA completely. We acknowledge the concern that the exclusion altogether of individuals with autism or learning disability from detention under the MHA at times of special vulnerability or crisis may well lead to the wrong use of the deprivation of liberty (or in due course LPS) provisions in the Mental Capacity Act 2005 (MCA) for detention in ATUs or mental health units, or, as recognised by the IMHAR, to misdiagnosis of a mental health condition in order to achieve admission under the MHA, or to an undesirable reliance on the criminal justice system.

82. If it is to be accepted that some limited use of the MHA for this group is capable of providing therapeutic benefit and a safe place in which to offer support, a necessary corollary to that must be robust safeguards, and the availability of skilled specialist inpatient facilities. The new statutory principles and changes to the admission criteria proposed, and an increased frequency of access to the tribunal are useful safeguards.

83. We think that the risks noted above associated with the exclusion of this group from the MHA are relevant also to the tightening of criteria under the MHA for this group. This highlights again the need for good specialist assessment and care for this group in the community, based on individualised plans and including the availability of suitable housing, to prevent detention in the first place.

Question 27

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

84. Please see our response above.

85. We are concerned that there are no express additional qualifying criteria for the detention of people with autism, as with learning disability.

86. We welcome the proposal that neither autism nor a learning disability will be mental disorders warranting compulsory treatment under section 3 MHA. This suggests that it will not be permissible to detain people with a diagnosis of autism, in the same manner as those with other mental disorders within section 1(2) MHA.

87. The current proposal is for a special procedure where "behaviour is so distressed that there is a substantial risk of significant harm to self and others (as for all detentions) and a probable mental health cause to that warrants assessment in hospital". The additional 'behaviour' criterion is intended to strengthen and expand the current qualification for learning disability under section 1(2) MHA. This and the requirement of a 'probable' mental health cause in addition, appear to raise the threshold for admission of this group. However, the interplay with the existing

criteria, is unclear. How does distressed behaviour add to, or how is it to be distinguished from, 'abnormally aggressive behaviour or seriously irresponsible conduct' for those with learning disability?

88. If admission under section 2 MHA is limited to those with a 'probable mental health cause' and continued detention under section 3 MHA is dependent on the existence of a mental health condition, diagnosed and with a treatment plan, then this is a welcome safeguard.

89. We are concerned that the limitation for section 2 MHA admissions may not be a realistic safeguard, and needs further explanation. Firstly, under section 2 MHA there will be only 28 days for this assessment to be completed, which brings into question the likelihood of a reliable assessment in this sensitive group with complex behaviours, in that time frame. It also raises again the question of the need for a specialist environment and specialist staff. The proposal does not identify what 'reasonable adjustments' are proposed. Secondly, the likelihood of a clear conclusion that there is no underlying mental health condition driving this behaviour so that discharge is the proper response may be difficult to achieve, or lead to detention as a default solution.

90. We note that there is to be a presumption that admission will be a last resort, and is aligned with the expectation that the Care (Education) and Treatment Review (CETR) is to form part of the admission decision.

Question 28

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?

91. Please see above.

Question 29

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?

92. We are unable to comment on this question without further justification for such a distinction. Currently, the admission criteria under the civil and criminal parts of the MHA are the same.

Question 30

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?

93. See above.

Question 31

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?

94. We strongly agree with this proposal, with the caveat that the provision and quality of care and treatment plans and care and treatment reviews is highly variable

at present. We support any proposals to achieve compliance with the recommendations of a CETR. We would like further clarity as to whether, and if so, how, it is envisaged that compliance will be enforced.

95. Please see responses to the proposals in chapter 4 on care and treatment plans.

Question 32

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?

96. There is a clear need for an increased supply of community services for this group so the commitment to create new duties of this kind is welcome, and should reduce the use of mental health inpatient services. It will require a commitment to provide adequate funding for such services. An effective and clear joint duty is required to prevent the current shifting of responsibility between local commissioners.

Question 33

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?

97. We agree with this proposal.

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?

98. We agree that more can be done to ensure the effective pooling of budgets to achieve a seamless provision of care without unreasonable delays. We can only consider the use of mandatory pooling in these cases as likely to be effective.

Question 17 – How should the legal framework define the dividing line between the Mental Health Act and the Mental Capacity Act

99. Any question as to how a person is deprived of their liberty must take as its underlying principle the need to ensure compatibility with article 5 of the European Convention.[17] We welcome any attempt to resolve the ambiguity created by the interface between the two statutory regimes, i.e. in respect of an individual who lacks capacity to decide whether to be admitted or to consent to the treatment but is not objecting to such admission or treatment.[18]

100. We share the concerns set out in the Review that the Mental Health Act regime has been used where it was considered that the Mental Capacity Act was too onerous. While acknowledging the administrative burden inherent in any application to deprive an applicant of their liberty under the DOLs regime following the *Cheshire West* decision, we do not consider that this presents a justification of derogating from fundamental rights: if an applicant is to be deprived of their liberty, there is an absolute need for that deprivation to be in accordance with the law and to permit access to a competent tribunal to enable judicial oversight.

101. That said, we are conscious of the need for clarity. We support in general terms the recommendation of the review that the deprivation of those who lack capacity but do not object should be authorised under the Mental Capacity Act.

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[17] See *HL v United Kingdom* (2005) 40 EHRR 32, which makes clear that detaining patients incapable of consent to admission must be through a procedure prescribed by law.

[18] *AM v South London & Maudsley NHs Foundation Trust* [2013] UKUT 0365 (AAC)

102. While we do not share the concerns that "objection" is difficult to identify (not least because any approach should focus on settled intention, not fleeting consent or objection and should always place – as noted above – the autonomy of the individual at the core of decision-making), we agree that terminology could be amended, so that the concept of "objection" is replaced with treatment being "against the person's known will and preference".[19] That would, of course, provide a tie-in with the proposals for prior consent. We also support the call for clear guidance on what objection looks like in practice.

103. We have some concerns about the use of the amended section 4B to address concerns where there is an ambiguity over a person's objection. The wording of section 4B is designedly tight to allow a temporary deprivation for "life-sustaining treatment or vital act", the latter being defined as an act which is "necessary to prevent a serious deterioration in P's condition". It is difficult to see how this wording fits with a situation where a person is being detained in order to ascertain whether they are consenting. We agree with the observation that this would require a further amendment of the Mental Capacity Act.

104. We question, however, whether that is an appropriate measure to take. Permitting deprivation for a period of 72 hours in order to determine whether or not the person is objecting is in our view a restriction on liberty that is difficult to justify. It is not accompanied by any (or any sufficient) procedural safeguards. Moreover, it is to address a difficulty which we are not convinced does or should exist – as noted above, ascertaining objection should not be outwith the scope of professionals dealing with these matters on a regular basis. We are also concerned about the potential

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[19] FN 132 of the Review.

“creep” of the powers under section 4B, which have been formulated to be narrow by definition.

105. In our view, any decisions as to deprivation should be based on clear decision-making. Accordingly, we believe that deprivation under the Mental Capacity Act should only occur where there has been a decision that an applicant both lacks capacity and is not objecting to the treatment; permitting a stop-gap or emergency measure to afford time for decision-making to be finalised is not appropriate in the context of this legislation.

106. As to the question of those who need to be detained not on the basis of the risk they pose to themselves but the risk they pose to others, we have some concern about the use of the Mental Capacity Act to facilitate such detention. There is a risk that such a development would blur the fourth principle of the Mental Capacity Act – i.e. that a person is not deemed unable to make a decision simply because the decision is an unwise one. Moreover, it has the potential to “leak” into decisions under the Mental Capacity Act on welfare matters – permitting decisions to be taken on the basis of their impact on others rather than the person.

107. Those concerns need to be balanced against the need for clarity in the division between the two statutory regimes.

108. Drawing those together, we take the view that those who need to be detained to protect others from harm, who lack capacity to make the relevant decision and who are not objecting to detention, should be managed under the Mental Capacity Act. Any other position risks undoing the beneficial work that the amendments and reforms are designed to promote.

109. Where we are in full agreement with the Review is that no steps can be taken or final decisions made until the new LPS arrangements have had time to "bed in". There will be teething problems with the new regime and it would be disproportionate to introduce into that process the additional burden of managing a new regime for balancing between the MCA and MHA.

110. We would suggest that a further consultation needs to take place on this issue once the government has clearer plans for a way forward and after the LPS has been in operation for a year. That consultation should include consultation on the relevant guidance.

Question 18 – advance consent

111. The consultation as drafted does not ask whether advance consent to informal admission should be permitted as a principle, but rather whether it should be set out in the MHA and the Code of Practice.

112. We have some concerns about the principle of advance consent. We do not agree with the Law Commission's view[20] that an applicant can agree to waive their article 5 rights in advance, without knowledge of the circumstances in which those rights would be violated or the nature of the confinement.[21] There is plainly a distinction between, on the one hand advance consent to a specific treatment or the withholding of a specific treatment at end-of-life stage and the speculative agreement to an unknown form of detention for an unknown period of time and subject to an unknown form of treatment.

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[20] Law Comm No 372, paragraph 15.8

[21] We do not accept that *HL v UK* (2005) EHRR 32 is authority for the propostion that a person can validly consent to confinement in advance.

113. It follows, therefore, that we disagree with placing such advance decisions on a statutory footing or including them in the Code of Practice.

114. If, however, the proposal is progressed, we are firmly of the view that safeguards are essential and should include the following –

- Any advance consent should only be given following discussion and the involvement of an advocate or mental health professional.
- Any advance consent should be subject to regular reviews to ensure it reflects the enduring intention of the person.
- Advance consent should be limited in scope, both in terms of the detention and treatment to which there is agreement and in time: we would suggest that advance consent should be only given for a limited period, such as 14 days.
- While a get out clause has some merit in tempering the interference with an applicant's rights, there are practical difficulties in ascertaining whether someone who lacks capacity can withdraw former consent. We do not understand how such a principle would work in practice.
- There would need to be a clear route of challenge by either an advocate or a Nominated Person to challenge any detention based on advance consent.

Accident & Emergency

115. We agree with the Review that the extension of section 5 of the Mental Health Act to permit a hospital to detain a person in crisis would be wrong and would not achieve the aim it seeks to achieve. It is wrong because it is unduly restrictive to extend the summary powers in section 5 to detaining a person who is in crisis; as such it would be, in our view, a violation of article 5 that would be difficult in a crisis situation to justify. It would not achieve the aim it seeks because, as the Review notes, the person may have reasons other than resistance to treatment that inform their decision

to leave A&E and the availability of support during the extended period of detention is unlikely to be sufficient to address the crisis.

116. We do not accept that limiting the enhanced power under section 5 to senior clinicians would assist, to the contrary we are of the view that it could create further delay and confusion for the person.

CHAPTER 10 Children and Young People

117. We note that there are no questions in relation to this section because matters are being advanced via the Code of Practice rather than new legislation. We further note that the IRMHA reported before the decision of the Supreme Court in Re D, which provided clarification as to the legal position concerning parental consent to admission to hospital in relation to 16-17 year olds who lack capacity to consent. The report did recommend that an IMHA is made available to children and young people who are in hospital, including those who are informal patients. It further suggested that the advocate should be trained to work with families as well as children and young people. It does not appear that these recommendations will be adopted. This is a matter of regret.

118. The review recommended that children and young people who are informal should also have a care plan review which could be on a statutory basis. We are pleased to see from the White Paper that the Government intends to follow this.

CHAPTER 11 The experiences of people from black, Asian and minority ethnic backgrounds

119. This chapter does not invite specific answers to questions. However, the mental and physical health inequalities endured by black, Asian and ethnic minority

communities, as laid bare by research[22] including the Independent Review, seemed to us to demand comment on the proposals contained in this chapter.

120. We welcome the proposals specifically targeted to addressing the disproportionate adverse impact of the mental health system on black and minority ethnic communities. In particular we consider that the following laudable aims are worth re-stating:

e. The pledged introduction of a new Patient and Carer Race Equality Framework designed to improve access and engagement and to include a requirement to monitor data in line with the Public Sector Equality Duty;

f. The promise to legislate to provide “culturally competent advocacy” following funding for pilots in 2022;

g. Allocation of up to £4M in funding to research projects aimed at identifying and explaining the causes of mental health problems in BME communities and to developing interventions tailored to specific groups and in particular to people, children and young people of black African and Caribbean descent;

h. The commitment to diversifying the cadre of senior mental health professionals and in particular to increase the representation of clinical psychologists of black African and Caribbean descent;

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[22] Chapter 4 of Byrne et al (Eds), Ethnicity, Race and Inequality in the UK: State of the Nation (Policy Press, 2020); Memon et al, *BMJ Open 2016*, 6; “Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England”; Royal College of Psychiatrists Position Statement on “Racism and Mental Health”, March 2018 (PSO1/18); Race Equality Foundation, 2019, “Racial Disparities in mental health: Literature and evidence review”. See also the profusion of reports on the impact of Coronavirus on BAME people: https://committees.parliament.uk/publications/3965/documents/39887/default/; https://www.bmj.com/content/372/bmj.m4921; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf.

i. The policy objective of reducing the use and duration of both detention and CTOs accompanying the proposed changes to the detention criteria;

j. The proposed move towards specialist mental health transportation vehicles in recognition of inappropriateness of conveyance in police vehicles and ambulances, particularly in the context of recorded fatalities and significant harm to black people during such journeys.

121. We look forward to further details of the funding streams that will be made available to facilitate the extensive cultural-change, re-organisation and re-allocation of resources, that will be required.

122. It is our view that the scale of the negative differential impact of the system on black and ethnic minority communities, and black African and Caribbean communities in particular, warrants urgent and bespoke intervention. Nonetheless, as observed in our response to the first consultation question, there is a need to anticipate future disparate impact on a range of potentially disadvantaged groups. This should relate not merely to averting known risks to particular groups, but also to the active promotion of positive health measures for those groups, targeted where necessary.

123. By way of example, the incidence of self-harm, suicide and suicidal ideation in the trans-community is alarmingly high as compared with the general population[23] and the Mental Health Foundation highlights a distinction in the reporting of mental health problems as between men and women, and suggests that rates of suicide and self-harm are higher in minority ethnic communities as compared to others.[24] The risks

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[23] https://www.lgbthealth.org.uk/wp-content/uploads/2018/08/LGBTI-Populations-and-Mental-Health-Inequality-May-2018.pdf.

[24] https://www.mentalhealth.org.uk/a-to-z/w/women-and-mental-health.

peculiar to women within the mental health estate appear to be reflected in the NHS Patient Safety Strategy 2019 referred to in the White Paper.[25] However, it is not clear, for example, how much defining identity characteristics such as gender, gender-identity, class and sexuality, informed the crafting of the new proposed detention criteria. Equally, vulnerability to mental ill-health in black African and Caribbean communities is linked to issues such as stigma, racialised poverty, and to the experiences of racial discrimination and poverty themselves. Indeed, poverty inevitably worsens mental health outcomes for many different groups, including women as a category.

124. What these highlights - based only on a limited survey of research material - reveal, is that the nature of the encounter with the mental health system is a complicated product of the intersection of a number of factors including disadvantage (or advantage) based on race, faith, gender-identity, gender, class and sexual orientation. Our concern is that the proposed reform grasps the opportunity not merely to improve the experience of those who come into contact with the mental health system, and those whose negative experience has been stark, but to begin to devise an integrated system conscious of the complex network of axes on which individuals live and experience mental ill-health.

Question 35: In the impact assessment, we have estimated the likely costs and benefits of implementing the proposed changes to the Act. We would be grateful for any further data or evidence that you think would assist Departments in improving the methods used and the resulting estimates. We are interested in receiving numerical data, national and local analysis, case studies or qualitative accounts, etc, that might inform what effect the proposals would have on the following:

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[25] See pp.97-98.

Different professional groups, in particular:

- How the proposals may impact the current workloads for clinical and non-clinical staff,

Independent Mental Health Advocates, Approved Mental Health Professionals, Mental
Health Tribunals, SOADs etc; and

- Whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered.

Service users, their families and friends, in particular:

- **How the proposal may affect health outcomes;**
- **How the proposals may improve the ability for individuals to return to work, or effects on any other daily activity;**
- **Whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered; and**
- **Any other impacts on the health and social care system and the justice system more broadly.**

Alternatively, please email your response to MHAconsultation2021@dhsc.gov.uk and
include what question you are responding to and your organisation (if appropriate).

125. We are not a professional organisation that is expert in data generation, numerical or statistical analysis. Our responses to Question 35 are therefore limited and gleaned specifically from the experiences of practitioners of mental health law.

126. We note that the extensive proposed changes to the framework for the provision of mental health treatment and care are going to require an immense level of investment in terms of capital, human resources and strategic leadership. These demands are onerous, and made more so by the challenges of implementation in the context of the COVID-19 public health crisis. It is only right, therefore, that the burdens on the workforce are properly recognised in the NHS Long Term Plan and its other relevant programmes of work. Right also that careful consideration be given to compliance with the Public Sector Equality Duty, the Equality Act 2010 more generally, and an imperative to gather reliable and meaningful data to assess other kinds of important impact perhaps beyond the strict requirements of Equality Act 2010 obligations.

127. Practitioners who work in the field are also especially aware of the training needs that will be generated by the plethora of new roles and procedures, and the pressures that will have somehow to be absorbed by health care and justice systems already strained to their every sinew. The institutional and cultural change necessary to truly shift focus from risk to recovery, and from dormitory to community provision, is not to be under-estimated. Less still, the culturally competent and methodical research work and community engagement necessary to address the way in which the system has failed, or might be failing, significant sectors of the population - sectors that are neither homogenous nor static in composition.

128. The proposals in the White Paper rest on years of evidence-based research and policy designed to make the system serve its intended users in a way that reflects an ever-deepening understanding of all of their multifarious needs. As alluded to in our response to question 1, there remains an important issue to be addressed at the level of theoretical underpinning. We believe that a general commitment to equality enshrined in the Act itself ought to be considered. If this cannot be included now, then

the drafters ought, at the very least, to begin to think about whether the observed problems of adverse impact on particular categories of person (those of non-Western ethno-cultural heritage, those with autism and those with intellectual disabilities) might actually reflect the continuing effects of a legislative history steeped in imperial-era notions of disability, race and eugenics.[26]

129. The formidable nature of the task ahead, to implement these proposals and then to look to further interrogation and re-casting of the foundations of the system, will require political will. We sincerely hope that the exceptionally hard work done by those who were involved in the Independent Review and the drafting of the White Paper will be matched by a commitment to ensure that the ultimate legislative proposals reflect the spirit of the recommendations made.

The Bar Council[27]
21 April 2021

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[26] See for example Jarrett, S; Those they called Idiots: The idea of the disabled mind from 1700 to the present day, Reaktion Books, 2020.

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