Mental Health Act Review - Impact in Practice?

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What does the future hold for the Mental Health Act?

With the full report of the government-commissioned independent review of the Mental Health Act now published, we have a clearer picture of the kinds of changes we could see becoming a reality.

In this briefing, we highlight the key recommendations which may shape how the mental health legal landscape of the future looks.

What might be changing?

Overview

The central message of the independent review is that the Mental Health Act (MHA) of the future should involve more choice and less compulsion.

Reflecting this, the review recommends introducing a new set of principles, which would sit at the front of the legislation itself and underpin everything within it, akin to the Mental Capacity Act.

The proposed principles - plus a flavour of the changes being recommended to support them - are:

- ***Choice and autonomy*** - Ensure that patients have more say in decision-making and that their choices/preferences are given more weight than in the past - e.g. recommendations include statutory Advance Choice Documents and greater rights to independent advocacy.
- ***Least restriction*** - Use the Act's powers in the least restrictive way - e.g. recommendations include tightening the criteria for detention and stipulating that patients must be objecting to admission before resorting to MHA.
- ***Therapeutic benefit*** - Deliver services in a way that minimises the need for MHA powers to be used and, where they are, support people to recover so they can be discharged - e.g. via proposed new Statutory Care Plans dealing with aftercare provision.
- ***Person as an individual*** - Respect each person's individual aspirations, priorities, needs, abilities and limits - e.g. it is recommended that Tribunal panel members be trained to become 'ticketed' in relation to particular specialisms, such as learning disabilities or autism.

The review makes 154 recommendations, all aimed at putting these underlying principles into practice.

Below, we look at some of the recommendations most likely to have an impact on the day-to-day workings of our mental health legislation, from admission through to discharge and beyond.

Admission/detention

The review is recommending some important changes which would affect the extent to which compulsory powers could be used to admit patients and increase thresholds for detention, including:

- Patients to be admitted informally with consent wherever possible, with the informal route to be given greater prominence by moving the current s.131 MHA to above s.2 and s.3.
- To be detained under MHA, the patient must be objecting. Otherwise, they should be admitted informally or - if they lack capacity - under the Deprivation of Liberty Safeguards (or Liberty Protection Safeguards, as they are likely to become). The review is proposing a 72 hour window post admission if needed to decide whether the patient is objecting.

- The criteria for MHA detention to be tightened to add a requirement for there to be a substantial likelihood of significant harm to the health, safety or welfare of the patient or another person plus a requirement that there is treatment available which would *benefit* the patient.

- Although a proposal in the interim report to merge s.2 and s.3 is not being pursued, over-use of s.2 is to be avoided - e.g. s.3 rather than s.2 should be used if the person has been detained under s.3 within the last 12 months (unless there has been a material change in circumstance since then) and if s.2 has already been used in the last 12 months.

- The initial period of detention under s.3 should be halved to 3 months maximum (renewable for a further 3 months, then 6 months, then annually thereafter).

Nominated Person

The review recommends that the current system of patients having no say over who their 'nearest relative' is should be replaced to enable patients to choose their own 'nominated person' (plus provision for a fall-back, interim nominated person where someone lacks capacity).

As well as the powers currently held by nearest relatives, it is recommended that the nominated person should have a right to be consulted (not just notified, as currently) about detention renewals, extension of Community Treatment Orders (CTOs), transfers between hospitals and discharge, plus a right to be consulted about care plans (where the patient consents) and a right to appeal clinical decisions to the Tribunal where the patient is unable to do so themselves.

Care and treatment

Some of the biggest changes to current MHA legislation being recommended by the review relate to decisions about what care and treatment patients receive in hospital.

Again, the focus of the recommendations is on giving patients more say over what happens to them, with a move towards putting treatment for mental disorder on a more equal footing with physical treatments.

Specifically, the recommendations envisage:

- More focus on shared decision-making and early review, with statutory Care and Treatment Plans (CTPs) - described as a 'cornerstone' of the review - to be in place for both s.2 and s.3 patients within 7 days of detention and reviewed (including considering the need for ongoing detention) at 14 days.

- Powers to treat patients without consent/against their wishes would be considerably tightened up, with an emphasis on making it harder for treatment refusals to be overridden. Broadly, what is being proposed is to have 3 categories of treatment (with the types of treatment falling into those categories to be subject to consultation) - Category 1 (which could never be given without the patient having capacity and consenting), Category 2 (which could not be given in the face of refusal by a person with capacity without a judge overruling that refusal) and Category 3 (which should follow the patient's preferences wherever possible/clinically appropriate).

- Second opinions from SOADs could be requested at a much earlier stage than currently - after 14 days or once the CTP is finalised, whichever is earlier.

- Introduction of statutory Advance Choice Documents in which patients can set out their wishes/preferences for care and treatment in the event of them losing capacity.

Discharge

Again, there are some significant changes recommended here, which focus on:

- No longer having 'hospital managers' hearings, having removed the right to apply for discharge via that route. (It is suggested that those currently undertaking the role of 'associate hospital managers' could instead take on a 'hospital visitors' role, aimed at monitoring day-to-day life at the hospital and ensuring patients' rights are protected).

- Increasing rights of access to the Tribunal, including a right to apply within the first 3 months for s.3 patients (reflecting the recommended new initial period of detention), new powers for SOADs or the CQC to refer to the Tribunal if they become aware of a material change in circumstance, a new power for Independent Mental Health Advocates and Nominated Persons to exercise a patient's right of appeal on their behalf, plus increasing the frequency of automatic referrals to the Tribunal if the patient does not apply.

Community/aftercare

In terms of care following detention in hospital, the review wants to see a reduction in numbers and duration of CTOs. With this goal in mind, the recommendations include:

- The criteria for a CTO should be tightened up in line with the recommended changes to the detention criteria, plus there should be a need to show that previous disengagement has led to a significant decline in mental health.
- Decisions to put someone on a CTO should require agreement from three professionals (as for detention) - two approved clinicians, including whoever would be the community supervising clinician for the CTO, and an AMHP.
- The Tribunal should have new powers to change CTO conditions (not just to discharge from a CTO as currently).
- The Nominated Person should be able to object to a CTO (as they can to a s.3 detention).
- CTOs should end after 2 years, although a new application with current evidence could be made at that stage.

If these changes do not result in a reduction in CTOs or improve their effectiveness after 5 years, consideration should be given to abolishing them.

The review also recommends:

- Introducing a new Statutory Care Plan (SCP) which would follow the patient through the system and would encompass details of aftercare provision.
- In relation to s.117 aftercare, addressing the lack of clarity/consistency about who should pay for what via national guidance setting out how budget responsibility should be shared.

Plus...

The review also makes a number of recommendations in relation to under 18s - e.g. there should be no informal admission based on parental consent for 16/17 year olds and possibly not for under 16s either (with a recommendation that the government should consult widely on this issue).

Some amendments to the MHA's criminal provisions (Part 3) are also recommended - e.g. 'relaxing' some of the restrictions in certain circumstances and giving magistrates' courts the power to remand to hospital for assessment/treatment from the time of the first hearing.

What next?

What happens next will depend largely on which of the review's recommendations the government accepts and which it does not. A key factor in this is likely to be the significant resource implications of a number of the recommendations - particularly, for example, around increased access to the Tribunal, SOADs and independent advocacy.

The government has already accepted two of the recommendations - replacing nearest relatives with a nominated person of the patient's choice and introducing statutory Advance Choice Documents for patients to express their care and treatment preferences.

We may have to wait a while longer to find out the position with regard to the rest, with the government saying it will issue a formal response to the review's recommendations 'in the New Year', before introducing a new Mental Health Bill setting out its proposed changes to the existing legislation.

How we can help

Our national team of mental health and mental capacity specialists have extensive experience in advising health and social care providers - both in the NHS and the independent sector - in relation to all aspects of the law in this area, including:

- Advice on all aspects of the Mental Health Act, including the impact of legislative changes;
- Advice on drafting and implementing policies that are compliant with legislative change and will withstand regulatory scrutiny;
- Representation at First Tier Tribunals;

- Advice on the interface between the Mental Capacity Act and Mental Health Act;
- Advice and representation in Court of Protection proceedings.

We also provide training on all aspects of the Mental Health Act and Mental Capacity Act, including induction and refresher courses for s.12 Approved Clinicians.

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