Written evidence submitted by Dr Lucy Series, Senior Lecturer in Law at Cardiff University School of Law and Politics (MHB0003)

Summary

The UK Government's draft Mental Health Bill[1] limits the scope of detention of people with learning disabilities and/or autism (LD/A) under the Mental Health Act 1983 (MHA). The policy intention is to prevent LD/A people from being detained inappropriately in mental health hospital settings.

Unfortunately, as currently drafted, the Bill will not prevent LD/A being detained in mental health settings, as they could then be detained under a different law – the Mental Capacity Act 2005 (MCA) – instead. The MCA contains Deprivation of Liberty Safeguards (DoLS), which will eventually be replaced by Liberty Protection Safeguards (LPS), which can also be used to authorise detention in health and care settings, including mental health settings.

Under the MCA DoLS/LPS, detention and treatment would receive less independent scrutiny, and rights of challenge are weaker.[2] **Paradoxically, taking LD/A people out of scope of the MHA may make it easier to detain them in mental health settings under the MCA instead, and make it harder for the patient or their family to challenge this.**

Legislative reforms to the MHA must also consider the role of the MCA to prevent these unintended consequences, and must address the root causes of admission and prolonged stay for LD/A people in mental health settings and why existing safeguards have failed to avoid worsening these problems other alternative legislation. This requires further careful consideration, which should fully involve LD/A people, and may not be possible during the timescales of this Bill.

Policy context

The Winterbourne View abuse scandal in 2011 exposed the inappropriate detention of several thousand LD/A people in 'assessment and treatment units' (ATUs). Successive policy initiatives[3] have failed to effectively prevent their detention, promote discharge, and support LD/A people to live in the community. Over a decade later, 3,575 LD/A people are in mental health hospital settings.[4]

Although people with 'psychiatric disorders'[5] are rarely detained for more than six months[6], 56% of LD/A people in ATUs have been there for over two years[7] and some have been there for decades.[8] As a 2019 Joint Committee on Human Rights (JCHR) inquiry found, the conditions of detention for LD/A people can be extremely restrictive, including high levels of physical restraint, chemical restraint using psychotropic medication, and prolonged periods of seclusion (solitary confinement).[9] The Care Quality Commission recently concluded that there are 'still too many' LD/A people in ATUs, 'They often stay too long, do not

[1] The Bill (published 27 June 2022) and supporting documentation can be found here: https://www.gov.uk/government/publications/draft-mental-health-bill-2022

[2] Lucy Series, 'On detaining 300,000 people: The Liberty Protection Safeguards' (2019) 25 International Journal of Mental Health and Capacity Law 2.

[3] Department of Health (2012) *Transforming Care*; NHS England, Local Government Association and Association of Directors of Adult Social Services, *Building the Right Support* (2015).

[4] NHS Digital, *Learning Disability Services Monthly Statistics, AT: May 2022, MHSDS: March 2022 Final* (2022).

[5] The Bill will create a new statutory term - 'psychiatric disorders' - meaning someone with a 'mental disorder' that is not a learning disability or autism.

[6] Wyatt S and others, *Exploring Mental Health Inpatient Capacity across Sustainability and Transformation Partnerships in England* (The Strategy Unit for the Royal College of Psychiatrists, 2019).

[7] NHS Digital, *Learning Disability Services Monthly Statistics AT: August 2021, MHSDS: June 2021* (2021).

[8] McCubbin J, '100 people held more than 20 years in 'institutions'' (*BBC News* 24 November 2021).

[9] Joint Committee on Human Rights, *The detention of young people with learning disabilities and/or autism* (HC 121 HL Paper 10, 2019).

experience therapeutic care and are still subject to too many restrictive interventions, which cause trauma'.[10] Reviews have found routine care provided in appalling conditions, 'bare cells with hatches'.[11] Following Winterbourne View, further institutional abuse scandals confirm that ATUs are dangerous places for LD/A people.

National policies accept that ATUs are the wrong model of care, and aim to promote good care in the community, providing LD/A people with a meaningful *home*.[12] Yet ongoing failures to discharge LD/A people from ATUs and cycles of readmission during crisis must be understood within a wider policy context of 'totally inadequate' levels of provision of community services,[13] and shortages of housing and skilled providers.[14]

After Winterbourne View, Care (Education) and Treatment Reviews (IC(E)TRs) were introduced for LD/A people in hospital or at risk of admission, to review their care and treatment and make plans for discharge and the support in the community. However, a recent independent review concluded these were beset by 'apathy' and a lack of 'accountability'.[15]

'Removing' learning disability and autism from the Mental Health Act 1983

Presently, most LD/A people in ATUs are detained under the MHA, usually under s3 MHA (longer-term admission for treatment), although substantial numbers are detained in connection with criminal justice proceedings (Part III MHA).[16] Charities like Mencap, the National Autistic Society and others have long campaigned for LD/A people who do not have a co-existing mental health problem to be removed from the MHA, on the basis that learning disability and autism are not 'mental illness'. Baroness Sheila Hollins argues that as these are lifelong conditions, LD/A people remain at ongoing risk of detention, which is discriminatory and unjust.[17] The hope is that by removing learning disability and autism from the scope of the MHA entirely this will prevent their inappropriate detention in mental health settings.

The recent independent review of the MHA did not recommend that LD/A be 'removed' from the MHA, noting that it was not established to consider this specific question,[18] drawing a contrast with a dedicated review on this question in Scotland.[19] Nevertheless, the government committed to limiting detention of LD/A people without a co-occurring 'psychiatric disorder' under the MHA to short-term periods for assessment only.[20] The draft Bill therefore 'removes' learning disability and autism from the scope of s3 MHA, permitting

---

[10] Care Quality Commission, *Out of sight – who cares? Restraint, segregation and seclusion review. Progress report* (2022).

[11] Alicia Wood and Sheila Hollins, *Thematic Review of the Independent Care (Education) and Treatment Reviews* (2021); Care Quality Commission, *Out of sight – who cares? A review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition* (2020).

[12] Local Government Association and Association of Directors of Adult Social Services, *Building the Right Support* (2015).

[13] Health and Social Care Select Committee, *The treatment of autistic people and people with learning disabilities* (HC 21, 2021).

[14] Wood and Hollins (n 11).

[15] Wood and Hollins (n 11).

[16] See analysis of NHS *Assuring Transformation* dataset by Chris Hatton, 'Winterbourne View 11 Years On. Report card 1: People being admitted to inpatient units, legal status and ward security' (*Chris Hatton's Blog* 2 June 2022).

[17] Sheila Hollins, Lodge K-M and Lomax P, 'The case for removing intellectual disability and autism from the Mental Health Act', (2019) *British Journal of Psychiatry* 1.

[18] Simon Wessely and others, *Modernising the Mental Health Act: Increasing choice, reducing compulsion* (Final report of the Independent Review of the Mental Health Act 1983, 2018) p179.

[19] Andrew Rome, *The Independent Review of Learning Disability and Autism in the Mental Health Act: Final Report* (Scottish Government 2019).

detention for treatment only for people with 'psychiatric disorders'.[21] The Bill's impact assessment predicts savings from reduced use of mental health beds for LD/A people as a result.[22]

The problem is, removing LD/A people from the scope of the MHA means they could be detained in ATUs under the MCA instead, under the DoLS or (in future) LPS. The impact assessment does not acknowledge this possibility.

Mental health detention under the Mental Capacity Act 2005

Since the 1960s, most LD/A people in 'mental handicap hospitals' would have been there 'informally' – without the use of the MHA, based on mid-century policies viewing 'compulsory powers' as unnecessary for them, as 'childlike' and tractable.[23] Then in 2004 the European Court of Human Rights ruled that an autistic man, HL, had been unlawfully deprived of his liberty in Bournewood Hospital after clinicians had admitted him 'informally' in his best interests.[24] HL's carers were unable to visit him there, or secure his discharge, and without the MHA they were unable to challenge his admission before a tribunal.

Following *Bournewood* the MCA was amended to include new Deprivation of Liberty Safeguards (DoLS) for 'incapacitated' people in care homes and hospitals. The DoLS were created instead of extending the MHA because many charities and organisations concerned with LD/A people view the MCA as less stigmatising,[25] and more 'empowering'.[26] Because of problems with the DoLS scheme, they will eventually be replaced by the MCA Liberty Protection Safeguards (LPS).[27]

Following a 2014 Supreme Court ruling on the meaning of deprivation of liberty,[28] most LD/A patients in ATUs today would be considered detained, meaning that either the MHA or the MCA must be used to 'authorise' this. Presently, this is mainly done via the MHA, but a few hundred people – including patients with dementia and some LD/A people – are detained under the MCA in 'mental health establishments'.[29] The choice of MCA or MHA to detain a patient in a mental health setting is subject to complicated 'interface' rules.

How the 'interface' between the Mental Health Act 1983 and the Mental Capacity Act 2005 works

At its simplest, the interface rules mean that if a person is both 'within scope' of the MHA (meaning a successful application could be made to detain them under s2 or s3 MHA) *and* they are objecting to admission or treatment for mental disorder, then the MCA *cannot* be used to authorise any detention.[30] This rule is why so many LD/A patients in ATUs are currently detained under the MHA and not the MCA.

---

[20] s2 MHA.

[21] Under s3 MHA a person can be detained for treatment for mental disorder for six months or longer. Currently s3 MHA applies to anyone with a 'mental disorder' meeting additional risk and treatment criteria, the Bill will limit its use to people with a 'psychiatric disorder' only (see n 5).

[22] Department of Health and Social Care and Ministry of Justice, *Draft Mental Health Bill 2022: Impact assessment* (June 2022).

[23] Lord Percy, *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency. 1954-1957* (Cm 169, HMSO: London, 1957).

[24] *HL v UK* [2004] ECHR 720.

[25] Department of Health, *Protecting the Vulnerable: the "Bournewood" Consultation: Summary of Responses* (Department of Health, 2006).

[26] E.g. House of Lords Select Committee on the Mental Capacity Act 2005, *Mental Capacity Act 2005: post-legislative scrutiny* (HL Paper 139, 2014).

[27] Mental Capacity (Amendment) Act 2019.

[28] *P v Cheshire West and Chester Council and another; P and Q v Surrey County Council* [2014] UKSC 19.

[29] Freedom of Information request, see: Lucy Series, *Psychiatric Detention under the Mental Capacity Act 2005* (*The Small Places* 3 January 2019).

The interface is notoriously complicated. One way of conceptualising it is to think of each law as different containers for flows of patients entering mental health settings for a variety of reasons linked to crisis and breakdowns in their care arrangements. The MHA was designed to be a smaller container, capturing a particular patient population and filtering out others. The MCA serves as an 'overflow' system, for patients who 'lack capacity' to consent to their care yet whom professionals still think should be confined and treated without using the MHA. If you filter patients 'out' of the MHA, the interface rules make them 'eligible' for detention under the MCA instead, including in ATUs, and even in situations where they (or their family) are objecting.[31]

Consultations prior to the draft Bill warned the government that removing LD/A people from the MHA could mean more were detained in ATUs under the MCA instead, and they would have weaker safeguards under the DoLS/LPS. The government acknowledged the risks of these unintended consequences, and committed to 'consider implications for the LPS in any reform and the design of which will be consulted on.'[32]

The Bill does not address these concerns and there has been no further consultation on the implications of taking LD/A people out of the MHA for the MCA DoLS/LPS. The Bill's impact assessment is based on a naïve assumption that removing LD/A from s3 MHA will reduce use of hospital beds, and does not grapple with the likelihood that the MCA will instead be used to authorise their detention.[33] (Bizarrely, it suggests they will be subject to guardianship in the community, when guardianship is almost never used today[34] and even in the community the MCA DoLS/LPS would be much more likely).

The Bill contains no provisions to guard against use of the MCA as an alternative to the MHA for LD/A people confined in ATUs. As a consequence, they are at risk of significant loss of rights and safeguards.

Fewer rights and safeguards for people detained under the Mental Capacity Act 2005

Because the MCA DoLS/LPS were designed for use in less intensively restrictive situations than 'objecting' patients in ATUs, they contain far fewer safeguards against inappropriate treatment and confinement than the MHA.[35] For example:

- Fewer professionals scrutinise applications for detention under the MCA than under the MHA, and may not be independent of care and treatment decision making.[36]
- Under the MCA, families lack 'nearest relatives'[37] rights to object to detention or seek discharge.
- Only 1% of DoLS authorisations are appealed (to the Court of Protection), whereas there are more than 50% as many mental health tribunal applications than detentions under the MHA,[38] partly

[30] For DoLS, see: MCA Schedule 1A. For LPS, see MCA Schedule AA1 Part 7.

[31] This is because of the logical construction of the rule: it is only being 'within scope' AND 'objecting' that makes a person 'ineligible' for the DoLS/LPS; if you remove them from 'scope' then the objections rule does not bite.

[32] Department of Health and Social Care and Ministry of Justice, *Reforming the Mental Health Act: Government response to consultation* (CP 501, 2021).

[33] Department of Health and Social Care and Ministry of Justice, *Draft Mental Health Bill 2022: Impact assessment* (June 2022) p101.

[34] In 2020-21 only 55 applications for guardianship were made. Applications for guardianship have declined every year for the past decade, because for most patients the MCA (and DoLS) are a more appropriate and acceptable framework for restrictions on their freedoms. NHS Digital, 'Guardianship under the Mental Health Act 1983, England, 2018-19, 2019-2 & 2020-21' (2021).

[35] For further details see written evidence from Dr Lucy Series (YDA0046) to the Joint Committee on Human Rights, *The detention of young people with learning disabilities and/or autism* (HC 121 HL Paper 10, 2019).

[36] Series L, 'On detaining 300,000 people: The Liberty Protection Safeguards', (2019) 25 International Journal of Mental Health and Capacity Law 2.

[37] The Bill will replace the 'nearest relative' with a 'nominated person', but they will retain similar rights and powers.

because the MHA requires automatic tribunal hearings after 6 months.[39]

- People detained under the MCA are not entitled to free after-care to support them in the community after discharge.[40]
- The MHA requires independent scrutiny of non-consensual treatment for mental disorder (including antipsychotic medications),[41] but the MCA does not.
- The MCA Code of Practice contains weaker provisions regarding seclusion and restraint than the MHA Code of Practice.
- Patients detained under the MHA have a right to complain about their treatment to the CQC; patients detained under the MCA do not.
- The draft Bill includes provision for statutory C(E)TRs, but these are not transposed to the MCA DoLS/LPS.

Removing LD/A from the scope of the MHA means many rights and safeguards that could potentially be used to scrutinise treatment and detention, and plan for discharge, will be weakened.

Problems with the MHA for LD/A people

Undeniably, the MHA has not served LD/A people well. It is not surprising so many LD/A people, families and campaigners view the MHA as part of the problem: many LD/A patients in ATUs will have had numerous assessments and tribunal hearings without this securing their discharge; the recent thematic review of C(E)TRs concluded that tribunals were not 'sufficiently strong in safeguarding the rights of people with a learning disability or autistic people who are being detained'.[42] The MHA's second opinion schemes for medication reviews are not effective in preventing antipsychotic medication being prescribed to LD/A patients.[43]

Most reviews and policy initiatives to 'transform care' following Winterbourne View did not consider the role of the MHA in prolonged admissions, nor whether the MHA itself could be adapted to prevent inappropriate admission and expedite discharge.

The recent MHA review sought to raise thresholds and strengthen safeguards for *all* detained patients, including LD/A patients, for example putting C(E)TRs on a statutory basis under the MHA (which is in the MH Bill) and giving the tribunal powers to *direct* that community care be provided (which is *not* in the MH Bill). However, the MHA review did not examine in any detail *why* existing safeguards were functioning so poorly for LD/A people specifically, and whether more 'root and branch' changes were necessary, for example of tribunal panel composition and culture, and the frequency and intensity of tribunal reviews.[44]

In contrast, the Scottish Government set up a dedicated review to explore law and policy in this area, designed to be 'the most accessible review of a law that we are aware of' involving LD/A people fully in the process.[45] A dedicated review could draw together the different threads of law and policy, encompassing the

---

[38] Series L, Fennell P and Doughty J, *Welfare cases in the Court of Protection: A statistical overview* (Cardiff University, Report for the Nuffield Foundation, 2017).

[39] MHA s68.

[40] MHA s117.

[41] MHA s58.

[42] Wood and Hollins (n 11).

[43] Care Quality Commission, *Survey of medication for detained patients with a learning disability* (2016).

[44] *Independent Review of the MHA* (n 18).

[45] Andrew Rome, *The Independent Review of Learning Disability and Autism in the Mental Health Act: Final Report* (Scottish Government 2019).

complex mental health and mental capacity law interface.

Implications of law reform options

- Amendments limiting the application of the MHA 1983 to LD/A people will make them eligible for detention under the MCA instead, and must address this interface.
- If LD/A people are diverted from the MHA to the MCA, then its 'safeguards' are considerably weaker under DoLS/LPS: there is less independent scrutiny of the basis for detention, fewer rights of challenge and (arguably) lower thresholds for detention.[46]
- Strengthening the MCA DoLS/LPS safeguards would require considerable and complex amendments to the MCA's schedules, which would have knock-on consequences for wider populations.
- Some may consider the Court of Protection a more appropriate forum for scrutinising detention and discharge planning than mental health tribunals for this population, but there are serious concerns about access to justice, cost and efficiency concerns concerning this court,[47] and there are examples of the Court of Protection *endorsing* long-term ATU admissions even where tribunals had discharged a person.[48]
- Neither the mental health tribunals nor the Court of Protection currently have powers to *direct* that alternative care be provided; they are forced to choose among the 'actually existing options', however undesirable.[49] The Wessely proposal (not included in the MH Bill) to give tribunals powers to *direct* community care provision could have tackled this.
- People discharged from s3 MHA are currently entitled to free after-care;[50] if they were detained under the MCA DoLS/LPS they would not be.
- Banning mental health detention of LD/A people under *both* the MHA or the MCA, or limiting it to a shorter period (e.g. 28 days for assessment) *might* be effective in focussing minds on discharge, but equally it might simply lead to widespread unlawful detention without any safeguards at all (as is currently happening under the DoLS[51]).

None of the above possibilities are straightforward or a silver bullet. Each would require more consultation and deliberation than may be possible during the passage of the MH Bill.

Recommendations

- A dedicated review should be set up to consider reform options, examining both mental health and capacity law and how these interact with discharge planning and social care delivery.
- People with learning disabilities and autism should be fully involved in this process, not only through accessible consultation but also deliberative democracy methods.
- Reform efforts should be directed towards strengthening, not weakening, safeguards, and explore how mental health or capacity law can *prevent* inappropriate admission, strengthen discharge planning and secure good community support for people with learning disabilities and autism.

About the author

This submission is by Dr Lucy Series (SeriesL@cardiff.ac.uk), a senior lecturer in law at Cardiff University.

---

[46] Fanning J, 'Continuities of Risk in the Era of the Mental Capacity Act', (2016) 24 Medical Law Review 3, 415; Lucy Series, *Deprivation of Liberty in the Shadows of the Institution* (Bristol University Press 2022).

[47] Series L, Fennell P and Doughty J, *Welfare cases in the Court of Protection: A statistical overview* (Cardiff University, Report for the Nuffield Foundation, 2017); Series L, Fennell P and Doughty J, *The Participation of P in Welfare Cases in the Court of Protection* (Report for the Nuffield Foundation, Cardiff University, 2017).

[48] *Northamptonshire Healthcare NHS Foundation Trust v ML (Rev 1)* [2014] EWCOP 2.

[49] E.g. *North Yorkshire CC v MAG & Anor* [2016] EWCOP 5.

[50] MHA s117.

[51] Joint Committee on Human Rights, *The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards* (HC 890, HL paper 161, 2018).

Dr Series is an expert in the MCA and its deprivation of liberty safeguards. Her recent monograph (*Deprivation of Liberty in the Shadows of the Institution*, Bristol University Press 2022) exmines liberty 'safeguards' under mental capacity law. She has given expert evidence to the Joint Committee on Human Rights' inquiries into *The Right to Freedom and Safety* and Human Rights in Care Settings, the National Institute for Health and Care Excellence on *Decision-Making and Mental Capacity*, and was on the Human Rights and Equality advisory group for the Independent Review of the MHA. She has been on the Care Quality Commission's advisory group on the MCA deprivation of liberty safeguards since 2011. Prior to becoming a legal academic, she worked with people with learning disabilities and autism in a variety of health and care settings.

8 August 2022