Written evidence submitted by the Care Quality Commission (CQC) (MHB0011)

Summary

We broadly support the draft Bill's proposals and welcome its ambition. We do however have some concerns about unintended consequences that may result from some of the provisions set out in the draft bill. Responses to the Committee's questions appear in the Annex to this submission.

Proposals in the draft Bill that change our Mental Health Act (MHA) statutory duties include:

- **Second Opinion Appointed Doctor (SOAD) Service**
  - Earlier access to SOADs (reduced from 3 to 2 months) to authorise detained patient psychiatric drugs without consent.
  - Urgent ECT procedures to save life will require SOAD certification if a patient has made an advance decision to refuse such treatment. SOADs can carry out the assessment remotely (e.g. via audio or video link) and this must happen within 48 hours.

- **Complaints Service**
  - More duties to inform patients of their rights and a specific duty to provide information about making complaints.
  - Extends the statutory duty to provide information rights to patients who have been conditionally discharged.

Proposals of concern:

Statutory monitoring powers – The draft bill does not make any proposals to expand CQC statutory monitoring powers to commissioning bodies (Integrated Care Boards). Our current statutory powers to monitor and request information applies to hospitals and local authorities only, and we have requested that this be extended to commissioning bodies in the Bill, as this will provide important support for our general MHA monitoring activities, as well as our investigations of complaints under the Act, and will be consistent with our new role in monitoring systems.

Urgent Second Opinion Appointed Doctor (SOAD) certification – We support the ambition to increase protections for patients under urgent ECT procedures. However, we have concerns about the impact of this proposal on patient choice. We are concerned that the criteria to override a capacitous patient decision must be robust and sufficiently detailed in the Act or Code of Practice to enable thorough scrutiny by whichever authority is assigned.

This new service would need significant government funding and support, including for an out-of-hours 24-hour SOAD service which CQC would be required to set up and manage. As predicted volumes of use of this service are unknown, and because we predict that

implementation would be resource intensive, it's questionable whether this proposal is proportionate to its intended aim, namely enhancing protection for patients. Currently, the SOAD service is not sufficiently funded by government for the routine service. We are in discussion with the Department of Health and Social Care (DHSC) about how our concerns about the proposal, as well as the needs of patients, can be addressed.

Remote technology – We support the proposal in the Bill that allows the option of the use of remote technology for urgent ECT SOAD assessment, although preliminary feedback from SOADs indicates that this method may not be appropriate in these circumstances. We continue to engage with DHSC to explore the feasibility and implications of this proposal. We believe this should also be extended for use in other routine SOAD assessments, where appropriate, otherwise this will lead to unmanageable cost pressures in an expanded SOAD service. A blended approach, where SOAD assessments can be undertaken either in person or remotely will help address the current backlog of assessments and will help support patients' needs.

People with a learning disability and autism – The current MHA identifies learning disability and/or autistic people within the scope of civil detention for treatment in hospital under the MHA. The draft Bill proposes to remove this, with the ambition to prevent inappropriate hospital detention. We support this ambition, however, there are risks:

- this could result in more people with a learning disability and/or autistic people being detained in hospital for assessment and then treatment of a co-existing mental health condition instead (e.g. anxiety);
- people may be detained in hospital via alternative routes to the civil part of the MHA, such as under the Mental Capacity Act, which offers less protection;
- Alternately, hospital detention could continue through increased use of the criminal justice powers of the MHA, or prosecution could lead to custodial sentencing, both of which could increase the likelihood of institutionalisation.

It is important to note that preventing inappropriate detention in hospital will also require investment in the provision of appropriate community alternatives, a message we have repeatedly delivered in a range of published reports, including our annual reports on the operation of the Mental Health Act and our Out of Sight – Who Cares? report.

Funding implications of the Bill for MHA Operations

Our statutory duties under the MHA are funded by grant in aid (GIA) from DHSC. Some of the draft Bill's proposals will increase the resources required to discharge our statutory duties and

[1] [1] The draft Bill's explanatory notes summarise DHSC's impact assessment as follows: "cost implications for bodies and organisations which derive from its proposed measures in England over a 14-year appraisal period. In healthcare and social care systems, ongoing costs for resourcing the reforms and upfront training costs for existing staff are estimated in the central scenario to total £436m for health care, **£46m for the Care Quality Commission** and £446m for Local Authorities (present values, 2022/23 prices). The increased frequency of referrals to the MHT creates costs for Her Majesty's Courts and Tribunals Service (HMCTS) and the Legal Aid Agency, estimated at a total of £171m (present value, 2022/23 prices) in the central scenario."

to ensure the needs of patients are considered and supported. The Government acknowledge this in the draft Bill and identify cost implications for bodies and organisations over a 14-year appraisal period, which include £46m for the Care Quality Commission.[1]

Introduction

1. The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage these services to improve.

2. We have specific duties and powers under the Mental Health Act 1983 (MHA) to protect and safeguard the interests of people whose rights are restricted under the Act. We have a statutory duty to present a published annual report to Parliament on the use of the MHA[2]. We are also the designated National Preventive Mechanism (NPM)[3] for health and social care in England, working with other members to independently monitor places of detention to prevent torture and inhuman and degrading treatment.

3. We are responsible for the appointment of Second Opinion Appointed Doctors (SOADs)[4] and manage the SOAD service. We receive over 15,000 requests for second opinions each year. The SOAD service safeguards the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are deemed incapable of consenting. The role of the SOAD is to decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient.

4. Our Mental Health Act Reviewers[5] make sure that the powers of the Mental Health Act are used properly, primarily by exercising the visiting function given to CQC under the MHA. Such visits are not CQC regulatory inspections under the Health and Social Care Act 2008, although they do inform our regulatory work - their core purpose is to meet in private with patients subject to the MHA and reflect back to services observations and concerns regarding their care and treatment in accordance with the MHA and code of practice. Mental Health Act Reviewers come from a variety of professional backgrounds, from social workers to lawyers, and are independent of the service providing care.

Our response to the draft Bill's provisions

Autism and learning disability (Including Schedule 1)

5. Our strategic focus on systems and pathways makes learning disabilities and autism one of our core concerns in monitoring the use of the MHA and regulation of services. We

[2] Monitoring the Mental Health Act Report
[3] National Preventive Mechanism
[4] Second Opinion Appointed Doctors
[5] Mental Health Act Reviewers

have previously set out clear expectations for Learning Disability and/or Autism services in our statutory guidance 'Right Support, Right Care, Right Culture'[6]. We have also made commitments in our 'Out of Sight – Who Cares? Restraint, Segregation and Seclusion Review'[7] to improve our regulation of services, developing a new approach to improve the way that we look at hospital and adult social care services for people with a learning disability and autistic people.[8] We are also publishing a report in due course[9], which is a review of the experiences of people with a learning disability and autistic people when they go to hospital, in due course.

6. We welcome proposed measures to place care, education and treatment reviews on a statutory footing, and to introduce a risk register to which commissioning bodies must have regard when providing alternatives to hospital admission.[10]

7. We fully support the ambition to prevent inappropriate detention under the MHA in hospital for people with a learning disability and/or autistic people. We believe that long-term detention under the Act frequently does not meet their needs and we understand the Government's objective in seeking to change the detention criteria in the MHA to avoid its use in such circumstances.

8. However, we also believe from our monitoring work and our involvement in Independent Care, Education and Treatment, Reviews (ICETRs) that in almost every case, the principal cause of such inappropriate detention is the lack of a practical alternative in the form of resourced community support. As a result of this lack of support, we have seen cases of hospital admission which could have been avoided altogether, in other cases, people continue to be detained in a hospital placement long after the justification for their admission has ended.

9. We are therefore concerned that changing the criteria for civil detention under the MHA would in itself be ineffective at preventing inappropriate deprivation of liberty in hospital of people with a learning disability and/or autism, unless there is adequately resourced community support for people who might otherwise end up detained in hospital as a last resort.

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[6] CQC: Right Support Right Care Right Care, Right Culture – How CQC Regulates Providers Supporting Autistic People and People with a Learning Disability [October 2020] https://www.cqc.org.uk/sites/default/files/20200929-900582-Right-support-right-care-right-culture-FINAL.pdf

[7] CQC: Out of Sight, How Cares? A Review of Restraint, Seclusion and Segregation for Autistic People and People with a Learning Disability and/or Mental Health Condition [October 2020] https://www.cqc.org.uk/sites/default/files/20201218_rssreview_report.pdf

[8] We will need to review and revise our MHA monitoring visit methodology and tools, including providing additional training and/or guidance for MHA reviewers, to ensure that we are able to monitor the introduction of, and ongoing compliance with, the additional safeguards introduced for persons with a learning disability and autistic people.

[9] CQC's report *Who I am Matters - A review of the Experiences of People with a Learning Disability and Autistic People when they go to hospital* will be published on 15 September 2022.

[10] NHS England: Care, Education and Treatment Reviews https://www.england.nhs.uk/wp-content/uploads/2018/09/cetr-booklet-health-social-care-providers.pdf

10. Further, we advise that the following unintended consequences of the current proposals could potentially arise and must be avoided:

    - *people with a learning disability and/or autistic people remaining in the same hospital placements; and new patients continuing to be admitted, under the legal authority of Deprivation of Liberty Safeguards (DoLS) or its eventual replacement, Liberty Protection Safeguards (LPS).* These legal frameworks arguably contain fewer protections than the MHA. For example, such patients would lose the right to First Tier Tribunal (Mental Health) hearings, and to the second opinion appointed doctor review of compulsory treatment. The legal framework of LPS is of particular concern because of the degree to which the treating clinician self-certifies authority to detain a person in hospital. This appears to us to be a potentially retrograde step in patients' legal protection where such patients are deemed incapable of giving or withholding consent to hospital admission.

    - *people with a learning disability and/or autistic people becoming subject to the criminal justice powers of the MHA through prosecution, with the aim of imposing a hospital order.* The proposals to bar long-term detention under civil powers will not apply under criminal justice powers of the MHA. We understand and sympathise with the view that this may be in the interests of patients currently within forensic psychiatric placements, or those who may in future be admitted to such placements, because otherwise prison might be used as a form of last-resort containment. However, the differences in criteria between the civil and criminal justice parts of the MHA could create pressure to prosecute people with a learning disability and/or autistic people to access hospital placements under the MHA. There would also be a risk that, by closing off civil routes to detention, pressures on forensic places become such that there is an increase in the use of prison in any case.

    - *people with a learning disability and/or autistic people being re-diagnosed with a concurrent 'psychiatric disorder' such that they meet the new criteria for long-term detention under the civil powers of the MHA.* This is a particular concern as such disorders could be of iatrogenic origin (i.e. anxiety or depression as a consequence of a placement that does not meet the individual needs of a person with a learning disability and/or or an autistic person).

Grounds for detention and community treatment orders

11. Overall, we welcome the draft Bill's ambition of seeking to reduce both detention under the MHA and the use of Community Treatment Orders, by changing the criteria for their use, including the introduction of a condition of 'serious' harm to the patient or others. Community Treatment Orders and their disproportionate use for people from Black and minority ethnic backgrounds are the subject of a CQC report to be published in due course. We would not want the definition of 'serious' to exclude hospital admission for

those that it is appropriate. This does raise the question of how 'serious' would be determined in law. However, these changes are unlikely to have any material effect on who goes into hospital, and why, under the MHA and that most existing cases could be reinterpreted to meet the new criteria. We would assert instead that the availability, or lack thereof, of earlier intervention and support for mental health in the community, and lack of community support on discharge from hospital are more important drivers of when and why the MHA is used.

12. In addition, we do not believe that these measures can by themselves deliver two central aims of the draft Bill, namely to reduce the use of the MHA overall, and the overrepresentation of people from Black and ethnic minority groups in the population, as both their causes are multifactorial.[11] Again, the availability of community resources is key to reducing hospitalisation and detention levels, and outreach to minority groups is one important factor in addressing health inequalities.

13. We are also concerned at the increasing difference in core values underlying civil detention under part 2 of the MHA and detention under the criminal justice part 3 of the MHA. The Bill's proposed amendments establish, for the first time under the MHA, substantially different scope and criteria for detention in hospital under these two arms of the MHA. The rationale appears to be that such changes to civil powers are needed to refocus the balance between rights and protection, but such a rebalancing in the criminal justice powers of the MHA could unhelpfully exclude mentally disordered persons within the criminal justice system from its diversion and treatment powers. It is of course vital not to make changes to the law that will have the unintended consequence of excluding people unjustifiably from mental health care. We believe that it is dangerous to allow different principles to emerge depending upon whether they are underlying part 2 of the Act covering civil detention, or part 3 covering criminal justice powers. All treatment under powers of the MHA should rest upon the same principled approaches, and differences between the safeguards of the two parts of the MHA must therefore be kept to a minimum.

Appropriate medical treatment

14. Under the proposed changes to the criteria for detaining someone under Section 3 of the Act, there should be appropriate treatment available. Treatment is considered appropriate when there is a 'reasonable prospect' that the outcome of the treatment would have a therapeutic benefit for the patient. This represents a change from the current wording that treatment must be 'intended' to have these effects. While we support the principle that the purpose of treatment under the Act should be for a person's therapeutic benefit, we believe that changing the wording from an 'intention'

[11] CQC: Mental Health Act- The rise in the use of the MHA to detain people in England, 23 January 2018, p19 Mental Health Act – The rise in the use of the MHA to detain people in England - Care Quality Commission (cqc.org.uk)

to produce a therapeutic benefit to 'a reasonable prospect' of delivering one through treatment is unlikely to produce a different result in clinical practice in most scenarios.

15. However, should the proposed amendment be made, it could open the possibility of legal challenge over whether, in circumstances of a patient's refusal to engage with psychological treatment, there was a 'reasonable prospect' of such treatment meeting the 'appropriate treatment' criteria. This could be seen as a benefit in terms of civil liberties, but it is an effect that successive governments have sought to avoid when defining treatability tests under the MHA.

The responsible clinician

16. The current legal definition of the 'responsible clinician' relies on a question of fact (i.e. which clinician has 'overall responsibility' for a patient's care.) In some circumstances this is unhelpfully vague. We therefore support the proposed amendment to the definition, which will clarify that the 'responsible clinician' is the person *nominated by the relevant hospital managers to have* overall responsibility for a patient's care.

Treatment

17. We support the ambition to increase protections for patients over the imposition of treatment without consent. We have called for a reduction in the time before a statutory Second Opinion Appointed Doctor (SOAD) is required to certify medication, and we welcome proposals to achieve this. With adequate investment, noting that a shortage of psychiatrists will mean challenges to recruiting sufficient numbers of suitable doctors, we will work with government to upscale the SOAD system to meet increased demand upon implementation. We also welcome measures in the draft Bill to increase the rigour and scrutiny of care planning, and of patient involvement in decisions. These are areas over which we have often engaged with services seeking to improve practice.

18. The MHA provides criteria for the urgent treatment of patients without the usual procedural safeguards in situations where such treatment would save life, prevent serious suffering or serious deterioration of a person's condition, or prevent the patient behaving in a way being a danger to self or others. We would like to see a tightening of the guidance and monitoring of the use of section 62, particularly with regard to urgent ECT and a statutory form introduced for such records, which requires details of the rationale for the intervention beyond a simple reiteration of the legal criteria. We think that having such records available for the scrutiny of medical directors and ourselves, during our regular MHA monitoring visits and SOAD certification, could ensure that clinicians' rationales are fully considered, articulated and recorded.[12]

[12] We have long been concerned that, where such powers are used, there can sometimes be inadequate recording of their justification, although services do now all use locally produced record forms in part at our instigation.

19. The draft Bill proposes to introduce a procedural requirement for SOAD certification in one particular circumstance where current practice would allow the urgent treatment powers to override that need. In practical terms, this situation would be where a patient has made an advance decision to refuse electro-convulsive therapy (ECT), does not have mental capacity, and a clinician wishes to override the advance decision on the basis that the intervention would save the patient's life. The patient would lack capacity to give or refuse contemporaneous consent.

20. The rationale for the above change is that, in practice, a patient for whom such an 'urgent' intervention is proposed will rarely, if ever, be taken straight away to an ECT suite, anaesthetised and given the treatment. This usually takes some time to arrange, and it is envisaged that it is in this window that the SOAD certification can be considered. We understand that regulations are to establish the criteria by which the procedure for an urgent SOAD certification may, in turn, be suspended should there simply be no time for this to take place and save the patient's life. We are concerned that any model to deliver this service will be sufficiently contentious that it will be extremely difficult to recruit SOADs to undertake these second opinions. SOADs have expressed concern in two recent workshops with CQC and DHSC about both the feasibility of these proposals from a practical point of view, and from the principle of overriding a capacitous refusal and the criteria needed to do so.

21. We are concerned that our SOAD administration has no out-of-hours element (i.e. is not a 24-hour service) that would make such arrangements practicable. We also do not necessarily have an existing pool of SOADs that would be able/available or otherwise engaged to undertake this work and would reiterate that the national shortage in psychiatrists will likely have an impact on success of implementation. At the very least it would require clinicians and non-clinical staff to be on call over weekends and bank holidays. This would require additional government support and funding. We also have concerns over the cost effectiveness and proportionality of such a service, which must always be on stand-by but may be used only very rarely. In addition, we are concerned about whether there is likely to be much scope for reasonable challenge of the decision to proceed with ECT, in circumstances where a patient, whose fitness for anaesthetic may well be declining by the hour, is at imminent risk of death. We are in discussion with DHSC about how these concerns, as well as the needs of patients, can be addressed.

22. In respect of the use of remote technology for SOAD assessments, we believe this should be available in all circumstances where a second opinion is required under the Act, not just for cases of emergency ECT, where in fact SOADs feel an in-person assessment is the preferred option. This is supported by evidence we have obtained from our own survey of 75 patients who had received second opinions, where only a minority expressed a positive wish for an in-person meeting with a SOAD.[13] At the

height of the pandemic, CQC used remote technology to continue providing SOAD service. The SOAD service continues, in part, to operate using remote communication, including between the patient and appointed doctor for some cases. We are therefore keen to ensure that an option to use remote technology continues, to maintain the service and meet the expected increase in demand.

23. We fully support the aim of ensuring that patients' wishes and feelings are taken into account in any decision as to whether to certify treatment on the basis of a remote interview, and we propose establishing a system upon implementation that would prompt responsible clinicians to supply us with information on the patient's preferences that would enable this to happen.

24. However, we believe that it is unnecessary to establish criteria for remote reviews using primary legislation. We do not think that the law should specify any criteria for overriding a patients' wishes and feelings over the procedure for a SOAD review. We believe that establishing such matters in generalised statutory language would invite legal challenge over procedural matters that would not be central to the effectiveness of the safeguard of the SOAD procedure.

25. We would suggest, instead, that the Code of Practice is the appropriate vehicle to set out the relevant criteria and underline that decisions about whether or not a remote SOAD review is appropriate must have regard to the patients' known wishes and feelings.

26. We believe it should be left to the SOAD to make a defensible legal decision to certify treatment taking account of all relevant circumstances of an individual case, having proper regard to the Code and the principles of the MHA.

Community Treatment Orders

27. We believe that the draft Bill's amendments to tighten the criteria for CTOs and the effect they can have are modest but helpful, and we endorse the intention of ensuring the use of CTO 'only where there is a strong justification'. We welcome the intention for a future review of CTOs following the proposed changes.

28. We support the proposals that nominated persons can object to making the CTO, and although such objection can be overruled on grounds of dangerousness to others, we

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[13] See Monitoring the Mental Health Act in 2021/22, page 85: If given a choice whether or not speak with a SOAD at all, only 41% (31 of 75) stated a positive wish to do so. Nineteen percent of patients (14) thought they would prefer that the SOAD just read their notes with no personal contact. The rest either had no preference (27%, 20) or were not sure which option to pick (12%, 9). One patient did not provide an answer. When asked their preferences about the independent doctor (SOAD) review, 21% (16) said they would prefer to see the SOAD in person but maybe wait longer, 28% (21) would prefer to have their treatment quickly but forego the opportunity to see a SOAD, 25% (19) said they had no preference, and 15 (20%) were not able to decide which option to pick. Four (5%) did not answer.

believe such a criterion is unlikely to apply in most cases where the risk is to the patient's own health or safety.

29. We also welcome the proposals requiring consultation with the community clinician before the CTOs are made or their conditions varied and for the Tribunal to recommend conditions of CTO be reconsidered.

30. In its response to the White Paper consultation, the Government stated that it wanted to see a decrease in the overall use of CTOs and the racial disparity in their application and would monitor the effect of proposed changes to their use over five years. CTO use is higher than originally anticipated when the powers were proposed, and it seems to be a very sensible idea to tighten the criteria and prevent it being used defensively or routinely without justification. We absolutely endorse the objective of reducing the disproportionate numbers of people placed under a CTO who come from ethnic minority groups, as highlighted by the Independent Review of the Mental Health Act[14]. It is not clear how changes to the criteria for the application of CTO would achieve this aim.

31. It remains a matter of debate across professional and user groups whether there can ever be a justification for using a CTO, with research not yet finding any tangible benefits of the power[15]. Nevertheless, we accept that CTO may yet provide a less restrictive alternative to what would be otherwise done to manage perceived risk. We therefore echo the findings of the Independent Review of the MHA that, at a suitable point following implementation of the draft Bill's proposals, there should be a review of CTO powers.

Nominated persons ***(including Schedule 2)***

32. We welcome the proposed changes to replace the 'Nearest Relative' role with a 'Nominated Person', so that patients can choose who undertakes this role. We have long suggested such a change, to enhance patient choice and autonomy, as well as to help protect family life, and we are pleased to see practical procedural measures suggested for the role's introduction.

Detention periods

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[14] https://www.gov.uk/government/groups/independent-review-of-the-mental-health-act

[15] [1] Burns T, Rugka˚sa J, Molodynski A, Dawson J, Yeeles K, Vazquez-Montes M, et al. *Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial***. Lancet** 2013; 381: 1627-33. For a critical view of this primary research, see Curtis D. *OCTET does not demonstrate a lack of effectiveness for community treatment orders* **Psychiatric Bulletin** (2014) 38, 36-39.

33. We support the proposed changes to the periods of civil detention under the MHA, which will help support patients' rights by increasing the frequency at which their detention is reviewed, including by the Tribunal. However, we recognise this may lead to additional workload for clinicians.

34. Some clinicians have told us that they are concerned about the additional workload implied by these more regular tribunal hearings, as the burden to demonstrate continued need for detention and treatment falls with the detaining authority. There is a risk that such burdens might have the effect of reducing the quality of reports for Tribunals or removing clinicians from other forms of patient engagement. There also needs to be adequate resources to enable patients the time and information needed to prepare for Tribunal and gain timely access to advocates.

Periods for applications and references

35. We welcome the draft Bill's proposals to extend the period in which patients can appeal against their detention to 21 days. We believe this is appropriate, in part due to the Tribunal's ability, using video-link, to arrange hearings at shorter notice.

36. We also support proposals to allow conditionally discharged patients subject to continued deprivation of liberty to appeal against the conditions of their discharge. We also endorse the proposals to shorten the time periods by which authorities must refer to the Tribunal any patient who has not made use of those opportunities to appeal.

Patients concerned in criminal proceedings or under sentence

37. We welcome the proposal to have a statutory time limit for arranging transfer of seriously mentally disordered prisoners to hospital. However, this will not in itself address the pressure on services and the likely unmet need in prison mental health services, which requires a much more far-reaching policy approach for sensibly targeted resources.

38. We welcome the proposals to introduce a power of conditional discharge into continued detention, but this must not become the default mode of such discharges from hospital. We intend close monitoring of its use, if it is implemented, and suggest that consideration is given to specific data collections and/or a notification system to track its use.

39. We remain concerned that an otherwise modernising draft Bill leaves untouched much of Part 3 of the MHA, which relates to patients involved in criminal proceedings.

Help and information for patients (Including Schedule 3)

40. We welcome proposals to extend the role of Independent Mental Health Advocates to informal patients in mental health hospitals. This brings the MHA in England in line with that in Wales and removes the current imbalance in patient rights where informal patients, who can still find their liberty restricted when receiving inpatient care and treatment, are not entitled to statutory mental health advocacy support.

41. We also support proposals to place a duty on hospitals to notify advocacy providers about qualifying patients and arrange for advocates to visit them. This is a form of 'opt-out' system that we have long called for, as opposed to the current much more limited duties on hospital managers to simply inform patients that advocacy is available.

42. We further support the proposed additional statutory duties for services to inform patients of their rights, including to provide information about making complaints (including to CQC), as well as to provide information to patients who have been conditionally discharged.

After-care

43. Overall, we support the proposed changes in relation to aftercare. In particular, we endorse the significant change to give the Tribunal the power to recommend that the relevant bodies make plans for the provision of after-care services. We believe this will help support the needs of patients, as the quality and the effectiveness of the treatment and care they receive after a period of detention is as important as the support they receive during it. The issue of timely post-discharge support is one we have raised before in our 'Out of Sight Who Cares' 2020 report[16] (page 46) and our Mental Health Act Monitoring Report 2021[17] (page 40).

44. This is an area where we have requested further powers under our monitoring and complaints remit. Under existing provisions of s.120, CQC can require hospitals and local authorities to provide such information that it may reasonably request in the course of its monitoring or investigation of the MHA. The MHA also provides a power to extend this duty to provide information to CQC to other agencies. We are calling on government to take this opportunity to add Integrated Care Boards (ICBs) to those organisations that must provide information and a response to any reasonable request by CQC, when we are exercising our MHA review function. Such a change would be in accordance with CQC's strategic aims of increasing our focus on systems of health and social care and across patient pathways, rather than provider units in isolation, supported through recent changes to the Health and Social Care Act 2008.

45. Commissioning bodies have specific duties under the MHA that can be a focus either of our general monitoring role or a complaint falling within the MHA remit. They have a

[16] Out of sight – who cares?: Restraint, segregation and seclusion review - Care Quality Commission (cqc.org.uk)
[17] Monitoring the Mental Health Act 2020/21

joint duty with local authorities under s.117 over the provision of aftercare; and a duty under s.140 to specify hospitals for the urgent reception of patients, and to specify beds that are suitable for under-18s. These duties fall equally on commissioning bodies and local authorities under the terms of the MHA, but there is some variation over how well they are implemented in practice and, in relation to s.140, the duty appears to be frequently ignored and/or not implemented in practical terms.

46. There are also cases where the substance of a complaint we may wish to investigate under our remit at s.120(4) involves decisions made by commissioning bodies.

47. This means that the absence of commissioning bodies from those listed at s.120B and 120C limits our ability to fully exercise our powers of review of the MHA and of investigation of complaints and hinders us from properly assessing these matters across systems. Insofar as commissioning bodies engage with us, they do so voluntarily, and we cannot compel an uncooperative body to give us information or respond to our concerns.

Miscellaneous

48. We support the proposal to bar the use of police cells and prisons as a place of safety for the purposes of the MHA. However, while the curtailment of the courts' power to use prison or police cells as a place of safety for mentally disordered offenders with nowhere else to go is welcome, as a regulator we will need to keep under review the consequences of these measures. This is because of the current intense pressure on forensic beds - which is likely to continue - which may cause demands to be made to services otherwise unsuited to meet the needs of acutely ill patients, who might be exhibiting violent behaviour[18]. To properly address this, adequate funding in both community and forensic services is required.

49. Similarly, we are concerned that potential unintended consequences, that would not be supportive of peoples' needs, could arise from the proposed bar on police stations being a place of safety for the purposes of sections 135 and 136 respectively of the MHA. While purpose-built health-based places of safety will always be more appropriate than a police cell in such circumstances, we believe that there may be situations where the police may choose to use criminal justice powers of arrest instead of MHA provisions, if they are concerned about whether a mentally disordered person could be safely contained in such a health-based place of safety (they may also be left only with the options of A&E or other less secure units, due to existing units being busy).[19]

[18] For example, there is some evidence that forensic patients are being admitted from other pathways into services that struggle to manage their care, for want of a bed at a more appropriate level of security.

[19] There is some anecdotal evidence that this happens already, even though theoretically police cells may still be utilised under s.136, and this may be for reasons of practicability or convenience.

Resource implications of the proposed reforms

50. Work with the Department of Health and Social Care (DHSC) is ongoing to model future requirements against predicted change in demand resulting from proposed MHA Reforms, which will form the basis of a submission in the next Spending Review.

51. The explanatory notes to the Bill provide a precis of the DHSC impact assessment:

- *"Cost implications for bodies and organisations which derive from its proposed measures in England over a 14-year appraisal period. In healthcare and social care systems, ongoing costs for resourcing the reforms and upfront training costs for existing staff are estimated in the central scenario to total £436m for healthcare,* ***£46m for the Care Quality Commission*** *and £446m for Local Authorities (present values, 2022/23 prices). The increased frequency of referrals to the MHT creates costs for Her Majesty's Courts and Tribunals Service (HMCTS) and the Legal Aid Agency, estimated at a total of £171m (present value 2022/23 prices) in the central scenario."*

52. In future years, when the MH Bill is enacted and implemented, DHSC has forecast considerable growth in the volumes in all the CQC's MHA areas. The primary example for the SOAD service is the forecast increase in s61 SOAD scrutiny from 2023/24, which will require significantly more SOAD time (89 Scrutineers will be needed to manage the 32,000 volume as opposed to current 10 Scrutineers and 4,000 volume).

53. Overall, we are forecasting (subject to quality assurance and more detailed analysis for specific proposals) a need for 341 regular, active SOADs, in comparison with the 106 active SOADs we had in 2021.

54. The urgent ECT proposals require detailed modelling but we already know that this will require additional clinical and non-clinical staff and different working patterns to administer.

55. Key areas of resource implications from MHA reform proposals are as follows:

- The need for a CQC implementation team to lead delivery of the necessary process and workforce changes into CQC
- Additional clinical staff (SOADs) as indicated above
- Additional non-clinical staff to administer the SOAD service and MHA Complaints
- Additional clinical and non-clinical staff to support delivery of the urgent ECT proposals
- Funding for scoping and delivery of digitisation and system improvements; including automation

56. Further scoping, analysis and testing is required before more detailed figures are ready for inclusion in DHSC's next Spending Review submission.

09 September 2022

For further information please contact Matthew Hughes, Senior Parliamentary and Stakeholder Engagement Adviser matthew.hughes@cqc.org.uk

Annex

Responses to questions

To note: All paragraph numbers refer to the accompanying Care Quality Commission (CQC) submission to the Pre-legislative Scrutiny Committee on the draft Mental Health Bill.

Q: How the changes made by the draft Bill will work in practice, particularly alongside other pieces of legislation including the Mental Capacity Act? Might there be unintended consequences and, if so, how should those risks be mitigated?

1. In paragraphs 10, 21, 48 and 49 of our response we refer to unintended consequences. These refer to people with a learning disability and/or autistic people remaining in the same hospital placements under DOLs or its eventual replacement LPS; people with a learning disability or autistic people becoming subject to the criminal justice powers of the MHA through prosecution, with the aim of imposing a hospital order; or people with a learning disability or autistic people being re-diagnosed with a concurrent 'psychiatric disorder' such that they meet the new criteria for long-term detention under the civil powers of the MHA.

2. We remain concerned that the proposed arrangements would not be practicable at this stage as our SOAD administration has no out-of-hours provision. At the very least it would require clinicians and administrators to be on call over weekends and bank holidays. This would require additional government support and funding. (paragraph properly assessing these matters across systems. Paragraph 49 refers to unintended consequences from barring police stations as a place of safety under the MHA.

3. We support the proposal to bar the use of police cells and prisons as a place of safety for the purposes of the MHA. However, as a regulator we will need to keep under review the consequences of these measures. This is because of the current intense

pressure on forensic beds, which may mean acutely ill patients are remanded to unsuitable services. (paragraph 49)

4. Similarly, we observe that there are potential unintended consequences that would not be supportive of peoples' needs that could arise from the proposed bar on police stations being a place of safety for the purposes of sections 135 and 136 respectively of the MHA. While purpose-built health-based places of safety will always be more appropriate than a police cell in such circumstances, we believe that potentially the police, concerned about whether a mentally disordered person could safely be contained in such a health-based place of safety (or left only with an option of A&E or other less secure units, due to existing units being busy), will choose to use criminal justice powers of arrest rather than the provisions of the MHA. (paragraph 49)

Q: Does the draft Bill strike the right balance between increasing patient autonomy and ensuring the safety of patients and others? How is that balance likely to be applied in practice?

5. We support the ambition to increase protections for patients over the imposition of treatment without consent, and a reduction in time before a statutory Second Opinion Appointed Doctor (SOAD) is required to certify medication (paragraph 17). We outline our views and concerns about this in paragraphs 17 to 26.

6. We welcome the proposed changes to replace the 'Nearest Relative' role with a 'Nominated Person', so that patients can choose who undertakes this role. We have long suggested such a change, to enhance patient choice and autonomy, as well as to help protect family life, and we are pleased to see practical procedural measures suggested for the role's introduction. (paragraph 32)

Q: To what extent will the draft Bill reduce inequalities in people's experiences of the Mental Health Act, especially those experienced by ethnic minority communities and in particular of black African and Caribbean heritage? What more could it do?

7. In paragraph 12 we explain that the overrepresentation of people from ethnic minority groups is multifactorial and therefore provisions for grounds for detention and community treatment orders may have a limited impact. In paragraph 30 we endorse the objective of reducing the overall use of CTOs, however there must also be a reduction in the disproportionate numbers of people placed under a CTO who come from ethnic minority groups, as highlighted by the Independent Review of the Mental Health Act. We support the government's monitoring of the use of CTOs.

Q: What are your views on the changes to how the Act applies to autistic people and those with learning disabilities?

8. We fully support the ambition to prevent inappropriate detention under the MHA in hospital for people with a learning disability and/or autistic people (paragraph 7). We are concerned that proposed measures will not prevent the long-term deprivation of liberty of people with learning disabilities or autism unless there is adequately resourced community support (paragraph 9) and we outline the consequences (paragraphs 10). We welcome CETRs becoming statutory and the introduction of an at-risk register (paragraph 6)

Q: To what extent will the draft Bill achieve its aims of reducing detention, avoiding detention in inappropriate settings and reducing the number of Community Treatment Orders?

9. We agree that long term detention frequently does not meet the needs of people with learning disabilities and/or autistic people (paragraph 7) and welcome the condition of 'serious harm' to the patient or others (paragraph 11).

10. However, we think that without adequately resourced community support, changing the parameters of civil detention under the MHA would be ineffective (paragraph 9). There are risks, for example that people with learning disabilities and people with autism will be placed in, or continue to be placed in, hospital, under the Deprivation of Liberty Safeguards or eventually the Liberty Protection Safeguards. These provisions have fewer protections for patients than the MHA. Patients might also be given a hospital order via the criminal justice system. We detail our concerns in full in paragraph 10 of our response. We also believe that a person's human rights should be respected regardless of legal powers used. (paragraph 13)

Q: What do you think the impact of the proposals will be on the workforce within community mental health services and multidisciplinary working practices both in inpatient and community services?

11. We remain concerned that our SOAD administration has no out-of-hours element that would make the proposed arrangements practicable. At the very least it would require clinicians and administrators to be on call over weekends and bank holidays. This would require additional government support and funding. (paragraph 21)

12. Some clinicians have told us that they are concerned about the additional workload implied by more regular tribunal hearings, as the burden to demonstrate continued need for detention and treatment falls with the detaining authority. Such burdens might reduce the quality of reports for Tribunals or remove clinicians from other forms of patient engagement. (para 35)

Q: What changes and additional support do you think will be needed to help professionals and the third sector implement the proposals effectively? Will additional staffing and resources be required?

13. Professionals and the third sector need to be informed about the legislative changes and given time to increase their capacity. Our response on help and information for patients is in paragraphs 40 to 42.

Q: How far will the draft Bill allow patients to have a greater say in their care, with access to appropriate support and avenues for appeal?

14. Regarding SOAD certification, we fully support the aim of ensuring that patients' wishes and feelings are taken into account into any decision as to whether to certify treatment on the basis of a remote interview, and we propose establishing a system upon implementation that would prompt responsible clinicians to supply us with information on the patient's preferences that would enable this to happen. (Paragraph 23).

15. We do not think that the law should specify any criteria for overriding a patients' wishes and feelings over the procedure for a SOAD review. (paragraph 24)

16. We suggest that the Code of Practice is the appropriate vehicle for decisions about whether or not a remote SOAD review is appropriate and must have regard to the patients' known wishes and feelings. (paragraph 26)

17. We broadly welcome the proposed changes to the periods of civil detention under the MHA, which will help support patients' rights by increasing the frequency at which their detention is reviewed, including by the Tribunal. (paragraph 33)

18. We welcome the draft Bill's proposals to extend the period in which patients can appeal against their detention to 21 days. We believe this is appropriate, in part due to the Tribunal's ability, using video-link, to arrange hearings at shorter notice. (paragraph 35)

19. We also support proposals to allow conditionally discharged patients subject to continued deprivation of liberty to appeal against the conditions of their discharge. We also endorse the proposals to shorten the time periods by which authorities must refer to the Tribunal any patient who has not made use of those opportunities to appeal. (paragraph 36)

20. We support the ambition to increase protections for patients over the imposition of treatment without consent. We also welcome measures in the draft Bill to increase the rigour and scrutiny of care planning, and of patient involvement in decisions. (paragraph 17)

Q: What do you think of the proposed replacement of "nearest relative" with "nominated persons"? Do the proposals provide appropriate support for patients, families and nominated people?

21. We welcome the proposed changes to replace the 'Nearest Relative' role with a 'Nominated Person', so that patients can choose who undertakes this role. We believe that practical procedural measures are suggested for the role's introduction. (paragraph 32)

Q: To what extent is the Government right in the way it has approached people taking advance decisions about their care?

22. The government is right about circumstances in which urgent treatment powers currently would override the procedural requirement for SOAD certification. (paragraphs 19, 20)

Q: What impact will the draft Bill have on children, young people and their families? Does it take sufficient account of the existing legal framework covering children and young people?

23. The absence of detail about commissioning bodies and their role makes it difficult for us to know this. (paragraphs 45- 47)

Q: To what extent are the proposals to allow for conditional discharge that amounts to a deprivation of liberty workable and lawful?

24. We support proposals to allow conditionally discharged patients subject to continued deprivation of liberty to appeal against the conditions of their discharge. We also endorse the proposals to shorten the time periods by which authorities must refer to the Tribunal any patient who has not made use of those opportunities to appeal. (paragraph 36)

25. We welcome the proposals to introduce a power of conditional discharge into continued detention but will be vigilant over the monitoring of its use, if it is implemented. We remain concerned that the draft Bill leaves untouched much of Part 3 of the MHA, which relates to patients involved in criminal proceedings. (paragraphs 38, 39)

Q: What are your views on the proposed changes in the draft Bill concerning those who encounter the Mental Health Act through the criminal justice system? Will they see a change in the number of people being treated in those settings?

26. We are concerned that prison might be used as a form of last resort containment. There must also be a risk that, by closing off civil routes to detention, pressures on forensic places become such that there is an increase in the use of prison in any case. (paragraph 10)

27. The Bill's proposed amendments establish substantially different scope and criteria for detention in hospital under these two arms of the MHA. We are concerned that such a rebalancing in the criminal justice powers of the MHA could exclude mentally

disordered persons within the criminal justice system from its diversion and treatment powers. (paragraph 13)

28. We generally support the proposal to bar the use of police cells and prisons as a place of safety for the purposes of the MHA. However, we will need to keep under review the consequences of these measures. This is because of the current intense pressure on forensic beds, which is likely to continue, which may cause remands to be made to services otherwise unsuited to meet the needs of acutely ill patients, who might be exhibiting violent behaviour. (paragraph 48)

29. Similarly, we observe that there are potential unintended consequences that would not be supportive of peoples' needs that could arise from the proposed bar on police stations being a place of safety for the purposes of sections 135 and 136 respectively of the MHA. While purpose-built health-based places of safety will always be more appropriate than a police cell in such circumstances, we believe that circumstances could arise where police, concerned about whether a mentally disordered person could safely be contained in such a health-based place of safety (or left only with an option of A&E or other less secure units, due to existing units being busy), will choose to use criminal justice powers of arrest rather than the provisions of the MHA. (paragraph 49)

Q: Are there any additions you would like to see to the draft Bill?

30. We are calling on government to take this opportunity to add Integrated Care Boards (ICBs) to those organisations listed in s.120B and 120C that must provide information and a response to any reasonable request by CQC, when we are exercising our MHA review function. Such a change would be in accordance with CQC's strategic aims of increasing our focus on systems of health and social care and across patient pathways, rather than provider units in isolation, supported through recent changes to the Health and Social Care Act 2008. (paragraphs 44, 45)

9 September 2022