

Written evidence submitted by Dr Duncan Double, Retired consultant psychiatrist (MHB0028)

I am a retired consultant psychiatrist and was a founding member of the Critical Psychiatry Network, formed in 1999 in the context of the previous attempt to reform the Mental Health Act (MHA) that led to the 2007 amendments. I blog at *Relational Psychiatry* (www.criticalpsychiatry.co.uk) and several of the posts over recent years have been on MHA reform. I attend meetings of the Mental Health Alliance and helped organise a national conference with Mind and Race on the Agenda (ROTA) in March 2022 on MHA reform. I have recently returned to work as a Bank MHA Reviewer for the Care Quality Commission.

Principles of the Act

I would have preferred if the government had been more ambitious and looked to replace both the current MHA and the Mental Capacity Act (MCA), which will still need reform as well as the MHA. Although the White paper said it would include principles on the face of the Act, the draft bill does not do so. The current principles in the Code of Practice need to be reinforced and built upon. The draft bill could be amended at least to make clear on the face of the bill that if people are admitted to psychiatric hospital, then admission should be truly informal whenever possible.

Community Treatment Orders (CTOs)

Understandably the government has been reluctant to reopen the controversy caused by the introduction of CTOs in the previous attempt to reform the MHA that led to the 2007 amendments. This has led to the compromise of the proposed CTO amendments in the draft Bill. The White paper indicated that there would be review of these reforms after 5 years to assess the impact of changes on reducing the use of CTOs and the effect of their application on racial disparities, but there does not yet seem to have been a government commitment to do so. The period before a further review could be reduced to 2 years.

However, it is clear that evidence for the benefits of the introduction of CTOs is lacking. Their use has prevented the advantages of using S17 leave before discharge leading to informal rather than formal community arrangements. I have pursued the reasons for continuing CTOs in the draft bill in correspondence with DHSC civil servants. To me, this seems to boil down to the fact that some patients feel they have benefitted from CTOs, which is true. However, these patients are already complying with the CTO, which cannot surely justify the need for compulsory powers. And the majority patient view, as for example reflected through the National Survivor User Network (NSUN) and Mind, is that CTOs should be repealed. I would agree that the lack of evidence for the effectiveness of CTOs, which seems to have been reinforced by research commissioned on the basis of the Wessely review, means that no further CTOs should be enacted. Current CTOs can be allowed to run their course.

Right to second opinion on medical, nursing and social matters

The introduction of the new S56(B) for Second Opinion Approved Doctors (SOADs) to ensure that the Responsible Clinician (RC) and other clinicians are complying with another new section 56(A) to follow a 'clinical checklist' when treatment is given under the Act is welcome. This checklist includes: that the patient's wishes and feelings as far as reasonably ascertainable are considered; reasonably practicable steps are taken to assist and to encourage the patient to participate in treatment decisions; people close to the patient are consulted; and any available forms of medical treatment are identified and evaluated. These requirements may need to be made clearer in a usable checklist in the Code of Practice. Making these duties of both RCs and SOADs clearer and legal will be helpful.

However, this strengthening of the second opinion process through SOADs does nothing to improve the right of the patient to have a second opinion of their own choice rather than that opinion being provided by a doctor appointed by the CQC. Often also, patients need second opinions not only on medical matters but also nursing and social matters, which a medical professional may not necessarily be the best person to provide. This failure to strengthen any right to a second opinion of the patient's choice on both treatment and

detention is a major weakness of the draft bill and does not reflect what is happening worldwide, for example in Victoria, Australia.

Improving advocacy

The introduction of opt-out arrangements for advocacy in the draft bill are welcome. However, the duty proposed on advocacy providers seems merely to be to arrange a visit and determine if inpatients want to use advocacy services. This does not necessarily imply that any service will be provided and government commitment to funding such arrangements is still awaited. The introduction of Independent Mental Health Advocates (IMHAs) by the 2007 amendments was never properly funded. The wording of the duty also needs to be amended so that it is applied to all patients that need advocacy, not just those that want a service. This would ensure that people without capacity are accommodated for advocacy, as well as those with capacity.

The draft bill should encourage a focus on commissioning arrangements for advocacy. I think this would give an opportunity for commissioning to create the provision of an integrated service of IMHAs, mental health lawyers and independent experts to improve joint working between these groups. In my view, such commissioning might be better managed through Integrated Care System (ICS) arrangements rather than by social service departments of local authorities. Mental health lawyers and independent experts can continue to be paid via legal aid arrangements, although the amounts of these payments I think require review. The advantage of a reinforced, integrated advocacy service is its independence, and I would like to see consideration given to creating a national advocacy service, rather than relying on piecemeal commissioning arrangements.

Compliance with UN Convention on the Rights of Persons with Disabilities (CRPD)

Coercion in mental health services needs to be reduced through making legislation compliant with CRPD. It would also be helpful if the draft bill was more associated with Seni's law (Mental Health Units (Use of Force) Act 2018) to reduce the use of force in mental health services. Appointment of a responsible person to reduce detention and

coercion under the MHA in each hospital with wider powers than provided by Seni's law may make sense. This person could liaise closely with the MHA monitoring division of the Care Quality Commission to help produce a national perspective to improve the rights of people with mental health problems.

Although the Committee on the Rights of Persons with Disabilities controversially argues that CRPD precludes all forms of involuntary commitment to mental health facilities, a CRPD compliant law would ensure that people with mental health problems are supported in their decision making and when they receive support that they are protected against abuse. The legal capacity of people with mental health problems needs to be protected even though they may not have mental capacity. It is not clear to me that the draft bill is compliant with CRPD. I think it is an issue which should be considered by the Scrutiny Committee, not necessarily taking CRPD to mean the abolition of the Act, which essentially is the position of the CRPD committee. There are problems with a number of human rights issues in mental health services. More generally rights and recovery-orientated services should be at the centre and not the margins of psychiatry. Psychiatry needs to stop coercing people into complying with treatments that may actually not be very helpful.

Extension of powers of Mental Health Tribunal

I was disappointed that the draft bill did not consider extending the powers of the Mental Health Tribunal (MHT) to treatment as well as detention decisions. This 'watering down' of the White paper proposals is unfortunate. If the proposal is not going to be reinstated then the bill could still create a right to a second opinion of the patient's own choice on medical, nursing and social matters, as mentioned above, and the draft bill could ensure that these opinions would have to be considered by the RC. The bill could also insist that the SOAD only approves any enforced treatment not only on the evidence from the RC but also from the independent expert providing a second opinion on behalf of the patient.

I do think, though, that any conflict with the RC on treatment as well as detention decisions should be a matter for consideration by the Tribunal if necessary. The Tribunal should have the power to require the RC to reconsider a specific treatment decision, as well as order

discharge, leave, transfer or community services, either immediately or within a recommended time period. Recommendations from tribunals should become more routine, especially if discharge, leave, transfer or community services cannot be ordered within a time frame. Progress on recommendations can be reviewed in any subsequent MHT if needed.

Addressing racial disparities in application of the Act and objectives of the draft bill

The Secretary of State for Health and Social Care when announcing the draft bill claimed that racial disparities will be addressed through greater scrutiny of decision-making, including a greater use of second opinions on important decisions and expanded access to tribunals. I do not think the draft bill goes far enough to change the current discriminatory nature of the Act.

Although the role of SOADs has been strengthened, as mentioned above, there is no increased availability of independent second opinions on the patient's behalf. Also, although advocacy arrangements are being strengthened, again as mentioned above, they do not go far enough. An improved advocacy service should actually reduce the number of tribunals, as tribunals will only be needed if agreement cannot be reached between the RC and the advocacy service about the care plan. The draft bill does not really consider the need to reduce the number of tribunals through improved advocacy. In fact, it seems to anticipate an increase in the number of Tribunals, which I do not think should actually be an objective of the bill. Earlier access to SOAD and MHT, which is more the intention of the draft bill, will actually increase costs rather than necessarily reduce detention.

SOADs may not be needed and can be abolished if the required 'second opinion' comes from the advocacy service rather than SOAD. It seems anachronistic still to have SOADs when treatment decisions should be more open to scrutiny in the MHT. Personally, I have no objection to Tribunals being reduced to a single judge rather than a panel. I think there are considerable savings that can be made with changes in MHTs and SOADs that can be invested in advocacy.

Criteria for learning disability and autism

The criteria for detention of people with learning disability in the current Act requires the presence of abnormally aggressive or seriously irresponsible conduct, which the draft bill calls serious behavioural consequences. Learning disability on its own has never been a sufficient reason for detention. It does concern me that there may well be technical, not always very meaningful discussions, about whether someone with learning disability or autism has a psychiatric disorder as well. I think separation of the Part II and III criteria is probably beneficial on this issue but I'm not clear why the serious behavioural consequences criterion for Part III detention does not seem to apply to autism as well as learning disability.

Prohibiting further admissions of Part II patients to secure facilities

The White paper talked about the warehousing of patients, primarily for learning disability, although this also occurs for those with serious mental illness. Too many people are spending too long in detention, particularly secure facilities. Patients seen as difficult to manage and place have been shipped out of the NHS to private care and to low and medium security, when they should be managed in more open-door environments. Mistreatment of such patients was revealed by *BBC Panorama* in undercover reports at Whorlton Hall and Winterbourne View hospitals and this scandal has gone on too long and must stop. The review by the independent Oversight Panel, chaired by Baroness Hollins, of people with a learning disability and autistic people, who have been placed in long-term segregation (LTS) under the MHA, found little evidence of any therapeutic benefit from hospital admission, and that people's health, dignity and well-being had been harmed.

Part of the problem, as the White paper recognised, is about patients who are difficult to place. There is a need for more community rehabilitation, which the White paper recommends for learning disability. It should also have recommended it for serious mental illness. But the issues are not just about difficulty in placement and lack of appropriate community resources. It is also about developing the skills to manage people with

disturbed mental states and challenging behaviour in a more open way in acute treatment to prevent further aggression and disturbance.

Proposals to improve the situation through Independent Care (Education) and Treatment Reviews have been insufficient. Obviously, people who have ended up in long-term secure provision do need to be helped to move on. But there is also a need for prevention of further such cases by prohibiting admissions to secure facilities under civil detention arrangements. In my view, civil detentions of people with learning disability and serious mental illness should just simply be prohibited to secure provision. This will allow secure services to develop their proper function of providing a therapeutic alternative to prison. Transfer to secure provision leads to unnecessarily long admissions. Prohibiting any further admissions of Part II patients to secure facilities either by legislation, or by direction from the Secretary of State, will help to create the right environment for the treatment of challenging behaviour for people with both learning disability and serious mental illness. It should also lead to the development of more community services to support such rehabilitation. The counter-productiveness of detention for challenging behaviour because of personality disorder needs to be recognised and more open specialist personality disorder services could be developed.

Supervised discharge for criminal cases

The history of the introduction of such enforced community arrangements should encourage caution about this proposal. It also seems to be counter to the impetus of the current reforms to open up services rather than increase coercion. Criminal law rather than mental health law should be used to impose any necessary deprivation of liberty on a capacitous patient on discharge. The difficulty in justifying this in criminal law should not mean the MHA is used as an alternative to introduce such restrictions.

Conclusion: Reversing re-institutionalisation of mental health services

There doesn't seem to be much point in reforming the Act if this process does not lead to a reduction in numbers of people detained, and it's not clear to me from the impact

assessment that a reduction in detentions is expected from the draft bill. Instead the expectation seems to be a slowing of the current increasing numbers of detentions. Any new or amended MHA needs to reverse the re-institutionalisation of mental health services since the closure of the asylums, particularly reflected by an increase in numbers of secure beds both in the NHS and private sector.

No further CTOs, prohibiting civil detentions to secure facilities, improving advocacy to create an integrated service of IMHAs, mental health lawyers and independent experts and extending the role and powers of the MHT to treatment as well as detention decisions (thereby making the role of SOADs redundant) would build on the deinstitutionalisation encouraged by the 1959 and 1983 MHAs. The government talks about wanting to modernise the 1983 MHA, but the draft bill does not go far enough in terms of reversing the re-institutionalisation of services that has taken place over recent years. What's being quietly forgotten is that a root and branch reform of the 1983 Act was initiated from 1999, followed by a several year process of expert review, green and white papers, draft Bill with parliamentary scrutiny and an actual bill, which in the end only led to the 2007 amendments.

The current reforms therefore need to be understood in the context of the over-preoccupation with risk in mental health services over recent years, which has been counter-productive. Risk is not always best managed by increasing coercion. True, the current reforms have been more motivated to reduce detention and inequalities in services more than to do with managing risk. But they do not go far enough in taking forward the 1959 and 1983 Acts to improve the rights of people with mental health problems.

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