Written evidence submitted by the Royal College of Psychiatrists (MHB0060)

1. The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists and setting and raising standards of psychiatry in the United Kingdom. It works to secure the best outcomes for people with mental health difficulties by promoting excellent mental health services, training psychiatrists, promoting quality and research, setting standards and being the voice of psychiatry.

Summary

2. We welcome this draft Bill as an opportunity to implement the recommendations of the Independent Review of the MHA and ensure it provides a modern legislative framework for the medical treatment of people with mental illness.

3. This submission is not exhaustive as a response to the key policy issues, for further information, we refer the Committee to our earlier submission on the White Paper on this matter.[1]

4. **Principles of the Act:** We strongly support the principles being in the Code of Practice to give a 'compass' to decision making under Mental Health Law.

5. **Racial Disparities:** We welcome the aim of the Bill to reduce the disproportionate number of individuals from BAME communities subject to detention, and emphasise that reform of mental health legislation is only one aspect of tacking structural issues of racial inequality which has far-reaching societal costs.

6. **Resources and workforce:** We recommend that funding is allocated to deliver the requisite workforce for the Mental Health Act reforms. This includes the additional 494 FTE psychiatrists needed by 2033/34, as identified in the independent research commissioned by the College, as well as the non-medical workforce identified by HEE-commissioned research.

7. **Legal definitions:** We recommend starting with the legal definition of mental disorder and keeping the established approach of using exclusion rules for the parts of the MHA where certain clinical conditions may be excluded.

8. **Learning Disability and Autism:** We have significant concerns about the potential consequences of the Government's proposals regarding learning disability and autism. These include the danger that people with LD presenting with such high-risk behaviours will be dealt with by the police and in the Criminal Justice System; the potentially discriminatory effect of differentiating the definitions of mental disorder in Part II and Part III; and that excluding people with Autism/Learning Disability from admission for treatment (section 3) would result in use of the Liberty Protection Safeguards (MCA) for the same detention but with fewer safeguards.

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[1] Royal College of Psychiatrists, Reforming the Mental Health Act White Paper: Royal College of Psychiatrists Submission (2021). Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/final-rcpsych-submission-to-mental-health-act-white-paper-consultation-2021.pdf (Accessed on 15 September 2022)

9. **Detention Criteria:** We recommend removing words from the Bill that encourage pseudo-exact probabilities/predictions for individuals about risk and suggest wording that will allow psychiatrists to evaluate risk in the individual case and give evidence more holistically and straightforwardly.

10. **Care and Treatment Plans:** We support care and treatment plans but we have some reservations that they are too managerially framed in the bill. These plans should be based upon good clinical assessments within adequately staffed multidisciplinary clinical teams.

11. **Community Treatment Orders:** We recommend that the committee return to the issue of CTO and consider new options for more pointed and restricted use of CTOs.

12. **Advance Choice Documents:** We support the principle of autonomy and choice and would be very happy to work further with the Committee and with Government to investigate how provisions in section 56A can be most effectively put in place.

13. **Supervised discharge:** We agree this could benefit a small group of patients who will be eligible for discharge into the community, but we advise caution over a significant risk that this could lead to more people being subject to conditions and restrictions in the community.

14. **Transfers from prison to hospital:** The imposition of strict targets such as this can incentivise change but there is also a risk that it leads to change that is not in the interests of patients and their health.

15. **Separation of Part II and Part III:** There is a strong clinical objection to the creation of a division between part II and III as any division will result in many of the principles that should apply to all people with mental disorder being watered down for this group.

Principles

16. We note that the Government has not followed the recommendations of the Wessely Review to place principles at the front of the Mental Health Act. We refer the Committee to our earlier submission on the White Paper on this matter.

17. Whilst we can appreciate that it may be difficult to insert principles into the primary legislation due to the amending approach to law reform that Government is taking, we strongly support the principles being in the Code of Practice to give a 'compass' to decision making under Mental Health Law.

Clinical judgement

18. Clinical judgement plays an essential role at many points in the legislation. The College would like to draw attention to this and to the fact that clinical training and an adequate workforce is vital to sustain and support the best possible operation of this complex and important legislation.

Addressing Racial Inequalities

19. The COVID-19 pandemic has had devastating effects on ethnic minorities and is widening further the health inequalities that exist. This, if unchecked is likely to lead to a rise in the involuntary detention of people of all races under the MHA and it will be essential

to tackle the structural issues at play to avoid the vast potential consequences on public health at enormous financial cost. The societal cost of health inequalities to individuals and groups is continued lack of cohesion and the economic costs arising from the welfare burden; healthcare costs and the lack of productivity are estimated to be in the region of £57 billion per year in England.[2]

20. The Wessely Report was clear that a 'combination of unconscious bias, structural and institutional racism, which is visible across society, also applies in mental health care.' Reform of mental health legislation is just one aspect of tacking structural issues of racial inequality in society and the mental health arena. We think that further action in the areas we highlight below will help move things toward greater racial equality in the manner the Wessely Report intended.

Resource provision and funding

21. The success of the proposals in this Draft Bill are reliant on adequate service provision, the absence of which would mean these proposals are unable to have any positive impact on the experience of patients. As has been noted before, mental health services are often vastly under-resourced. The Independent Review of the Mental Health Act found that patients in mental health facilities are often placed in some of the worst places in the NHS estate. The Review found that badly designed, dilapidated buildings and poor facilities are not a safe place for staff to work and for patients can contribute to a sense of containment atmosphere and make it hard for effective engagement in therapeutic activities.[3] Mental health services have been under intense pressure for many years, and it only stands to get worse as the full impact of the pandemic is beginning to be seen in services. The CQC's annual report, Monitoring the Mental Health Act in 2020/21, notes that '*staff are now exhausted, with high levels of anxiety, stress and burnout, and the workforce is experiencing high levels of vacancies'.* The report goes on to add that '*working under this sustained pressure poses a challenge to the safe, effective and caring management of inpatient services and to the delivery of care in a way that maintains people's human rights'.*[4]

22. We greatly welcome the recent announcement of £150 million for mental health units, which will begin to tackle many of the longstanding issues existing in under-resourced mental health services. However, there has not yet been any certainty provided on future funding to implement the reforms, which will be essential.[5]

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[2] The Health Foundation (2020) Health Equity in England: The Marmot Review 10 Years On - The Health Foundation (Accessed 15 September 2022)

[3] Wessely S. Modernising the Mental Health Act: Increasing choice, reducing compulsion. UK government; 2018. Available at: https://www.gov.uk/government/publications/modernising-themental-health-act-final-report-from-the-independent-review (Accessed on 15 September 2022)

[4] Care Quality Commission (2021) *Monitoring the Mental Health Act in 2020/21*. Available at: 20210127_mhareport_printer.pdf (cqc.org.uk) (Accessed 15 September 2022)

[5] For further information, please see our July 2022 submission to A WORLD LEADING MENTAL HEALTHCARE SYSTEM BY 2035: COMMITMENTS FOR A CROSS-GOVERNMENT MENTAL HEALTH AND WELLBEING PLAN

Workforce Implications of the reforms

23. Current workforce constraints mean that changes to the Mental Health Act cannot be absorbed within the existing workforce. While funding announced by the Government for workforce expansion in March 2021[6] is a good first step, much more will be required.

24. To support policy-makers prepare for successful implementation of the reforms, RCPsych commissioned The Strategy Unit to provide an independent assessment of the impact of the proposed changes to the Mental Health Act on the psychiatric workforce.[7]

25. It is important to acknowledge the complexity involved with quantifying the workforce implications of the reforms. Estimating how the rate of detentions will change over the coming years is particularly complicated, which is why RCPsych commissioned The Strategy Unit to model different growth scenarios.

26. Assuming a continuation of current detention and CTO growth, our estimate is that an additional 520 WTE psychiatrists will be required as a result of the reforms by 2033/34. 27. 27. Under DHSC's moderated detention growth assumption, this reduces to 494 additional psychiatrists. In in the 'no detention growth' scenario, the estimated additional number of WTE psychiatrists reaches 417 by 2033/34.

28. While RCPsych welcomes reforms to the Mental Health Act to improve patient care and increase safeguards, it cannot be emphasised enough that they are not deliverable without the required investment in the psychiatric workforce.

29. We recommend that funding is allocated to deliver the requisite workforce for the Mental Health Act reforms. This includes the additional 494 FTE psychiatrists needed by 2033/34, as identified in the independent research commissioned by the College, as well as the non-medical workforce identified by HEE-commissioned research.

Definitions

30. The Bill leads with clinical definitions of Autism and Learning Disability and introduces the term 'psychiatric disorder'. To our knowledge this is the first time mental health law has tried to define clinical conditions in primary mental health legislation and the first time the term 'psychiatric disorder' has ever been used in statute. We think these definitions conflate the legal concept of mental disorder with the clinical concepts and that it will be confusing.

31. We strongly recommend starting with the legal definition of mental disorder and keeping the tried and tested approach of using exclusion rules for the parts of the MHA where certain clinical conditions may be excluded. This is the approach taken in the 1983

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[6] Department of Health and Social Care. Mental health recovery plan backed by £500 million. March 2021. Available from: https://www.gov.uk/government/news/mental-health-recovery-plan-backed-by-500-million (Accessed 15 September 2022)

[7] The Strategy Unit, *Estimating the impact of the proposed reforms to the Mental Health Act on the workload of psychiatrists* (2021). Available at: Estimating the impact of the proposed reforms to the Mental Health Act on the workload of psychiatrists | The Strategy Unit (strategyunitwm.nhs.uk) (Accessed 15 September 2022).

Act. We recommend using secondary legislation to give definitions of specific clinical conditions and removing the term 'psychiatric disorder' in the Bill.

32. The College view on the Bill's exclusion of autism/Learning Disability for admission for treatment (section 3) is one of significant concern (see below).

Learning Disability and Autism

33. Regarding the proposed reforms to Learning Disability and Autism, we commend the emphasis on supporting people with Learning Disability (LD) in the community but we have substantial concerns about potential negative impacts following the implementation of these reforms.

34. There are times when community services cannot manage the level of risk that some patients with LD present with. This is not just because of lack of services or staff, but because some risk levels require treatments in appropriate and safe hospital environments. There is a real danger that people with LD presenting with such high-risk behaviours will be dealt with by the police and in the Criminal Justice System (CJS) if they cannot be admitted to hospital under the MHA. There is the potential of significant risk to the public if neither the MHA nor the CJS can be used to divert people with LD in crisis situations to appropriately supportive therapeutic environments. The worst outcome of the reforms would be more people with LD being incarcerated in prison. There is already circumstantial evidence that fewer people with LD are diverted from the Courts, potentially due to changes in legal aid funding etc., and the draft legislation would make the situation worse. Furthermore, it could also lead to inappropriate use of high doses of antipsychotic medication to safely manage the situation in the community

35. We are concerned that differentiating the definitions of mental disorder in Part II and Part III of the Mental Health Act would be discriminatory and disadvantage the care people with LD would receive.

36. This might lead to a situation where people do not receive appropriate social and health care because they will not be entitled to section 117 aftercare.

37. We are concerned that excluding people with Autism/Learning Disability from admission for treatment (section 3) would result in use of the Liberty Protection Safeguards (MCA) for the same detention but with fewer safeguards.

38. Regarding Care Education and Treatment Reviews (CETRs), currently, failure to implement CETR is often due to problems with the ability of Local Authority and/or education to provide services under their responsibility. Making the mandate stronger will not have any effect if the services are not available. The role of the responsible clinician is designated under the MHA legislation to which the CETR process is not subject. A psychiatrist is not always involved in the CETR process and therefore the Consultant Psychiatrist should not be apportioned responsibility for implementing tasks that are out of their clinical responsibility. If formalised, a mechanism to consider disagreements to the recommendations would be required before they were formally incorporated into a care plan.

39. It is essential that the Government consider these concerns and looks to mitigate the potential negative impacts on patients if the Autism/Learning disability amendments do go through. We would welcome the opportunity to work further with the Committee and with Government to investigate how this may be achieved. Some proposed mitigations are detailed below:

40. Currently, community services cannot manage the level of acuity that people with LD can present with because supported living models are not designed or equipped to provide the constant support and models of care required. As a result, to support the reforms there would need to be a substantial increase in the funding and commissioning of community services for people with LD.

41. Embed in the Act a mechanism to monitor the effect of the reforms, examining the extent to which they are having the intended effect and what if any unintended consequences occur.

42. Include in the Bill an obligation on the Secretary of State to report to Parliament on the progress made.

Detention criteria (clause 3):

43. We note with concern that the Bill introduces new criteria for Section 2 (admission for assessment) and for section 3 (admission for treatment) and at various other points in part II (e.g. sections 5, 17a, 20 & 20a). We further note that these are different from the recommendations of the Wessely Review.

44. For example in S2 the new criteria created by clause 3 of the Bill are:

> (2) An application for admission for assessment may be made in respect of a patient on the grounds that—
>
> > (a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period;
> >
> > (b) serious harm may be caused to the health or safety of the patient or of another person unless the patient is so detained; and
> >
> > (c) given the nature, degree and likelihood of the harm, and how soon it would occur, the patient ought to be so detained.

45. We wish to draw attention to the wording in (c): "Given the nature, degree and *likelihood* of the harm, and *how soon it would occur*, the patient ought to be so detained." (italics added).

46. The words 'likelihood' and 'how soon it would occur' connote probability and prediction in the individual case. This is notoriously difficult and these new statutory words can be expected to generate confusion. Probabilities apply to groups and what is needed are clinical judgements of the potential harms in the individual case. It is very important that

psychiatrists are not expected to provide pseudo-exact probabilities/predictions for individuals in Mental Health Act assessments.

47. We strongly recommend removing these words from the Bill and replacing S2(2) (c) (and other relevant sections) with “given the nature and degree of the potential harm the patient ought to be so detained”. This will allow psychiatrists to evaluate the kind and quality of the potential for harm to self, health or others, its relation to the mental disorder in the individual case and give evidence more holistically and straightforwardly.

Care and Treatment Plans

48. We support care and treatment plans but we have some reservations that they are too managerially framed in the bill. These plans should be based upon good clinical assessments within adequately staffed multidisciplinary clinical teams.

Community Treatment Orders

49. The use of CTOs, following their introduction in 2007, was significantly higher than predicted and their use is associated with marked racial/ethnic disparities. The changes proposed in the Bill are very limited and offer no serious prospect of their use being restricted (which was the Wessely Review recommendation after hearing the evidence supporting their use). We therefore strongly recommend that the committee return to this issue and consider new options for more pointed and restricted use of CTOs.

Advance Choice Documents (ACDs)

50. We note that government have not followed the recommendations of the Wessely Review to put ACDs on a statutory footing. We refer the Committee to our earlier submission on the White Paper on this matter. We support the principle of autonomy and choice and would be very happy to work further with the Committee and with Government to investigate how provisions in section 56A that relate to ACD can be most effectively put in place to secure their known benefits. This should include up to date briefings on advance choice (including race equalities) from experts.

Appropriate medical treatment: therapeutic benefit

51. The introduction of a requirement of likely therapeutic benefit, when detention for treatment is recommend, is welcomed. “Reasonable prospect” may be open to interpretation and we recommend clarification in the subsequent Code of Practice where reference to ‘evidence-based treatment’ might help constrain arbitrary predictions about therapeutic benefit.

Nominated persons

52. We welcome this proposal. It is particularly important for patients who come into forensic mental health services as it is not uncommon for a patient to have been abused by the legally designated nearest relative. The College looks forward to working with government to ensure that the reformed process is implemented in a way that improves patient choice and safety.

Part III changes

Supervised discharge (Clause 30)

53. The proposed changes for conditionally discharged patients (section 37/41) to allow for conditions to amount to a deprivation of liberty - 'supervised discharge' - in cases where the alternative would be continued liability to be detained, is welcomed for this small group of patients. This small group of patients will benefit from being eligible for discharge into the community, when previously this was not possible.

54. There is however a note of caution to be sounded, which arises in the context of a culture of blame - when for example, patients under the care of mental health services commit violent offences - which is still experienced by many psychiatrists. There is a significant risk that the interpretation of this change will lead to more people being subject to conditions and restrictions in the community because the supervised discharge arrangements will be recommended for most people, out of caution. It is necessary to point out that (almost) every person detained under section 37/41 will have a history of harming other people and many more people than intended will therefore risk being caught up in this change. This may tip the balance overall, to increasing restrictions and reducing people's control over their lives after discharge into the community. This is the opposite of what the amendments are aiming to achieve. People who previously, after discharge were free to come and go as they pleased, could be subject to curfews, escorting arrangements, and close supervision. If this situation is realised, then there will be significant workforce and financial implications.

55. The case of MM does not represent a very common scenario. We are aware of work being undertaken to try and establish how many people nationally, with learning disability or, who are autistic, would fall under the same circumstances as MM but it is expected to be very few (there may be others with other mental disorders who would be affected). The amendment may be necessary because of the disadvantage to these few patients, but we express caution about an unusual case leading to a change, possibly adversely affecting large numbers of people. We would encourage further consideration of whether the legislation can emphasise that this provision should only be used in exceptional circumstances.

56. The proposal goes beyond the circumstances of MM (who had capacity to consent to the deprivation) by including people who lack capacity to consent to any deprivation of liberty. If the overall proposal goes ahead, we support that it applies to people irrespective of whether they have the relevant capacity.

Transfers from prison to hospital (Clause 31)

57. We support any reasonable attempt to ensure that people in need of urgent treatment in prison, receive this, as quickly as possible in hospital. There is already guidance that people should be admitted within 28 days. This does not happen in most cases but this is not going to be remedied by only amending legislation. Investment in prisons, prison mental health, community psychiatry and secure hospitals should occur before any statutory standard takes effect, otherwise it will risk having no impact.

58. Some people do not need hospital admission within 28 days. We acknowledge this is a small number of people. For example, people accessing hospital-based, specialist personality disorder services. There may need to be further consideration of whether these situations should be recognised in the legislation.

59. The unintended consequence of this change, in the absence of any significant investment in the services described, is that it forces clinicians to change their threshold for recommending admission to hospital so that those people, who most urgently need admission, do not breach this 28-day requirement. A further possible unintended consequence is that there is an increase in people being admitted to hospital and then remitted to prison prematurely to manage the target.

60. The imposition of strict targets such as this can incentivise change but there is also a risk that it leads to change that is not in the interests of patients and their health.

Separation of part II and part III of the Act

61. There is a strong clinical objection to the creation of a division between part II and III although we appreciate that government may view part II and part III as serving different public policy purposes. Any division will result in many of the principles that should apply to all people with mental disorder being watered down for this group. If people in prisons have a right to equivalent care then the Mental Health Act should reflect that value. Additionally, creating this distinction between the two parts will be confusing for patients, and without any medical or evidential basis in terms of public protection.

62. The removal of autism and learning disability as qualifying mental disorders is dealt with above but whatever the final decision; we do not support a different approach for part III. The reality of the current situation is that when part III of the Mental Health Act is applied to autistic people or people with learning disability it is almost only when there is another mental disorder diagnosed, and which is the basis for detention. Any fear that dangerous people with learning disability or who are autistic, will suddenly fall between every legal provision directed towards public protection is speculative and we would argue, unjustified. Whatever the final decision on the status of autism and learning disability, the two parts should be allied.

Detention criteria

63. There is no proposed change to the 'treatability' test within sections of part III. This decision implies that people falling under part III might still be detained even if there is no reasonable prospect of treatment being effective (as would be required in part II). We see no practical benefit in terms of public protection other than to create the impression – by maintaining this distinction – that psychiatric hospitals can serve as de facto prisons without offering treatment that is likely to be effective. We suspect however, that creating this distinction will simply create an unnecessary and confusing division between the two parts without any significant change in who is detained and when. Notwithstanding our comments on the new detention criteria generally, we do not support a significant difference between part II and III.

16 September 2022