Supplementary written evidence submitted by Professor Sir Simon Wessely FRS, Chair of the Independent Review of the Mental Health Act (MHB0092)

On behalf of myself and the Vice Chairs of the Independent Review of the Mental Health Act, it was a pleasure to give evidence last week to your committee. It was an excellent session.

Given that in the end because of Parliamentary business meaning you became inquorate, we are grateful to you for asking us to set out some further matters in writing that it was not possible to cover at the evidence session.

This letter is signed by myself as Chair of the Independent Inquiry, but the three Vice Chairs have all contributed and approved the final version.

Our approach

We would be remiss if we did not emphasise, again, that – in lay terms – our recommendations were designed to be a package deal, not a pick and mix. Our approach to the key issues, including all of those addressed in the balance of this letter, was premised on the basis that, taken together, they would offer the best chance of reducing disparity in over-representation of Black people in the MHA, improve experiences under the MHA, and drive increased access to alternatives to detention. This would not simply be through compliance with the law, but crucially through the fact that greater requirement to hear the patient's voice provides the best opportunity to increase therapeutic alliance and trust between those in need of assistance (including, in particular, those historically subject to discrimination) and services.

Principles

We remain committed to the importance of having principles on the face of the Bill. A further point that we would have wished to draw out had we had time is that we are aware that there is a concern that it is not possible to 'retrofit' principles onto existing legislation. However, since we wrote our report, the Armed Forces Act 2021 has been passed, inserting a new s.343AA into the Armed Forces Act 2006; that section requires 'due regard' to be paid to a new set of statutory principles relating to the Armed Forces Covenant. We suggest that such provides an example of how retrofitting can be done, and also the correct approach: i.e. that those discharging functions under the Mental Health Act 1983 are to have due regard to the statutory principles.

Advance Choice Documents

The Committee will be aware of the weight that we placed in the Review upon these documents and, as discussed in the evidence session, of the multiple purposes that they can serve, including as a concrete step towards reducing racial discrimination. One point that we did not have the opportunity to cover given the time constraints was our concern that, although the substance of our approach to ACDs has been provided for in the draft Bill, the draft Bill does not provide statutory provision for supporting people to make such documents. Absent such statutory support (to include, where relevant, advocacy support), we are concerned lest the very real potential that ACDs will not be realised as widely as it should.

Advocacy

Time did not enable us to have a detailed discussion of advocacy during the evidence session. For the record, we have two key points that we would have wished to make.

First, we are pleased that the draft Bill tracks our recommendations and proposes to expand the provision of advocacy, including to informal patients (in England, such provision already applying in Wales). As noted above, advocacy support is also of importance to those making ACDs, and it should be expanded to enable this (which would require advocates to be able to support those who have been discharged, but are at risk of further detention). Done properly, and with a proper eye to true (rather than token) cultural competency, advocacy can also be a powerful tool to help secure against racially discriminatory practices.

However, we remain concerned that there are unresolved issues about the issues of training, accreditation, standardisation, accountability and regulation of advocates. We recommended during the Review a full consultation on how to secure the right balance between 'professionalising' advocacy and preserving its power as a disrupter of professionals. We note that the Government committed in its response to the White Paper consultation to further explore with stakeholders the best way to improve the quality of IMHA services; we would hope that the Committee will be able to deploy such means as it can to hold the Government to this continued work.

Learning disability/autism

It was clear that the Committee recognise that, as we had previously identified, the issues involved are complex and finely balanced, as indeed Baroness Hollins said. We continue to have an instinctive reservation about relating rights to any specific diagnosis, in particular in the context of detention. Amongst other reasons, this is because of the uncertain boundaries that continue to surround diagnostic classification in psychiatry that have and will continue to be subject to change as knowledge increases, the risk of a 'bidding war' between different groups, and finally

the considerable overlaps that already exist between the categories. We are also mindful that the dangers of institutionalisation and detention extending long beyond the point of any therapeutic benefit are not limited solely to autism and learning disability, but apply to all diagnostic categories subsumed under the label of mental disorders.

Our preference in the Review was, and remains, for the issues that arise in the context of learning disability and autism to be addressed by a specific review whose terms of reference enable all the relevant legislative frameworks to be taken into account (including the Mental Health Act 1983, the Mental Capacity Act 2005, the Care Act 2014 and the Social Services and Well-Being (Wales) Act 2014). This was the model adopted in Scotland by the Rome Review, which has fed, in turn, into the Scottish Mental Health Law Review, and a commitment by Scottish Government to introduce at Learning Disability, Autism and Neurodiversity Bill 'to uphold and protect the rights of autistic people or people with learning/intellectual disabilities.' We recognise that such would take time but, as we emphasised in the evidence session, we envisage that many of our recommendations, if implemented, would already start to create real changes for autistic people and those with learning disability. In this regard, we should, though, perhaps highlight our concern that the draft Bill does not include our recommendation that the Tribunal be given the specific power to direct community provision in situations where people have become 'stuck': a phenomenon that appears disproportionately to affect those with learning disability/autism. The draft Bill provides for the Tribunal to have the power to make recommendations in this regard, but we fear that this is an insufficient lever for these intractable cases.

Tribunals

We trust that the Committee found the exchanges in relation to our approach to the role of the Tribunal in treatment challenges helpful in terms of allaying misunderstandings. Time did not permit us to set out our views that that is an area where it would be very sensible if the Bill could provide for Tribunal powers to be amended by way of secondary legislation so as (1) to enable it to determine treatment challenges; and (2) to pilot such challenges. Such would enable testing of the Tribunal's role, and hence a better understanding of whether its benefits in terms of acting as a backstop to give teeth to patient choice outweigh its costs. We are also conscious in saying this that, as legislation in this area is effectively generational, then if no provision is made at this stage, the opportunity to do so will be lost for a very substantial period.

Community Treatment Orders

We noted the views of the Committee as to CTOs. As we recognised in the Review, the case for them is (to put it mildly) not overwhelming, outside, perhaps, the limited scope for them in the forensic context to secure an ability of patients to be discharged from hospital within a clear framework. We have also been troubled by the fact that the racial disparity in their use has become even more glaring since we reported. If CTOs are to remain, we believe strongly that all of the hurdles and safeguards that we recommended in the Review should be included (including the time limit and the power of the Tribunal to direct changes in the conditions).

We do consider it necessary to note, however, that if the Committee is minded to say that CTOs should be removed, that it is also aware of the potential that at least some who may currently be on CTOs may be recalled and placed on long-term s.17 leave instead. This would have some troubling consequences, not least the fact that a patient on s.17 leave is subject to the full force of the Part 4 treatment regime, whereas patients on a CTO are – deliberately – subject to a treatment regime which provides far less scope for coercion. The differences between the two treatment regimes would be lessened if the draft Bill is enacted in its current form, but will still remain. The Committee will therefore no doubt wish to consider what mischief removing CTOs is intended to redress, and how to ensure that such does not simply reappear under another head.

Detention criteria

Time prevented a full exchange in relation to our recommendations in relation to detention criteria. Our starting position is that we do not think care should ever be contingent upon detention, so changes to detention criteria should not impact upon the duties upon the State to secure adequate care for those in need of it. Our approach was, however, predicated upon our perception (informed by our engagement with stakeholders) that the current detention criteria can be misapplied to allow detention in circumstances where there is, in fact, no sensible therapeutic benefit that can be offered and/or without requiring a proper evaluation of the risks that the person is actually at or may pose. Tightening up the criteria will allow greater transparency and accountability; we would be troubled – and surprised – if it meant that those who actually require admission in circumstances of confinement were denied it.

Informal admission and advance consent

We touched upon the importance of informal admission as a goal in the evidence session. Part of the thrust of our recommendations was to bring about, sustain and develop cultural change. That was intended to include making informal admission the proper starting point in any consideration of admission. To give up on the

potential for admission to hospital for mental health treatment save under the framework of administrative detention would be to give up on the goal of achieving parity between mental health and physical health treatment. As a marker of the importance of this goal, we recommended that the legislative provision for informal admission should be moved from s.131, in the 'Miscellaneous and Supplemental' part of the Mental Health Act 1983, to the head of Part 2, immediately following the newly-introduced principles. This would be achievable without any further legislative changes to the current s.131, but would provide an important nudge to those applying the Act to consider whether informal admission is possible.

It is, however, important to emphasise what we are not saying in the paragraph above. We could not reach consensus during the Review about whether it should be possible for a person to give advance consent to admission in circumstances of confinement (which would mean that they could be admitted informally to hospital at a point when they lack capacity to consent to their admission, even if they were to be confined there). We recognised that there were difficult issues of principle at stake, including a tension between supporting the exercise of legal capacity and the potential for people to be admitted absent adequate safeguards to identify whether their prior consent could truly be relied upon. We recommended that Government should consult as to whether the Act should provide for this. Whilst the Government consulted in its White Paper, it did so on the basis that the right to give advance consent is already recognised in law. The draft Bill does not therefore provide for statutory recognition of the ability to give advance consent; however, its premise (and hence, we presume, the premise of the updating Code of Practice) is that there is no need for such recognition. This means that there are no statutory safeguards included in the draft Bill to reflect the potential for admission on the basis of advance consent. The Committee should be aware, however, that we were surprised to see the basis of the Government's consultation on this issue. We proceeded in the Review on the clear basis that advance consent to mental health admission was not already recognised in law, such that a specific statutory change would be required to provide for it. We remain of this view, and trust that the Committee will be able to make observations in respect of this issue, notwithstanding the fact that – for the reasons set out above – it does not appear in the draft Bill.

Nominated person

As we made clear during the evidence session, we are pleased that the draft Bill tracks the majority of our recommendations in relation to nominated persons. We recognise the power of the point made by Rosena Allin-Khan MP in relation to the person who does not have family or friends who might be willing to be nominated. However, this is in reality a problem which does not afford of any direct legislative

solution, even if its effect may be lessened by the much closer attention that will be required in focus to the person's own wishes in relation to their care and treatment.

However, so that the Committee is clear, we need to add to the list of matters that we regret that the draft Bill does not include the fact that it does not give the power to remove (now) nominated persons to the Tribunal, and that it does not include the power to overrule a specific decision of the nominated person, but otherwise to leave them in post. The fact that termination of the appointment of nominated persons will remain with the County Court means that these important decisions will remain with a judicial body that has only limited and erratic exposure to mental health matters through such applications. Given that (in principle) the nominated person will be a person chosen by the individual in question, the termination of their appointment is a more serious matter than it was before and may have adverse effects upon the person who has chosen them. Accordingly, we considered, and remain of the view, that it would be wiser to allow a power to overrule a nominated person's decision without having to terminate their appointment, as is presently the case. We consider that the Tribunal would be able to distinguish between a nominated person who makes a bad decision in good faith and one who is (in effect) simply vexatious and should be removed.

Further input

We are happy to provide any further input if/when required.

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