Written evidence submitted by Care England (MHB0099)

Summary

Statutory principles

- Despite the Draft Mental Health Bill being predicated on statutory principles at the White Paper stage and widespread support for the inclusion of these human rights-based principles, they are excluded from the draft Bill in its current form. We are disappointed at their exclusion in the draft Bill and would argue strongly for their re-insertion.

Admissions under the Mental Health Act

- The draft Bill fails to recognise that older people with mental disorders, people with ABI, and those with neurological conditions and LDs, other than those involving autism, also suffer from the problems of resourcing and inappropriate use of detention under the Mental Health Act (MHA).

- The Bill must further consider the effects of the change from deprivation of liberty safeguards (DoLS) to liberty protection safeguards (LPS), which will reduce the safeguards available to protect the essential rights of people who lack capacity, especially since the LPS will further differentiate between the use of the MHA and the MCA LPS, for both people living with LD/A and those with other LDs, acquired brain injury and dementia, by relying on the tricky concept of 'objection.'

The delivery of appropriate care

- The proposal to differentiate access to MHA section 3 between 'civil' patients and those in prison, when diagnosed with similar disorders, appears clearly discriminatory. If enacted, this does nothing to support the essential human rights of a significant proportion of vulnerable people who are wrongly channelled into the criminal justice system.

- Flexible, person-centred care provision in the community must be prioritised and resourced, which currently it is not. Without this, as pointed out at the White Paper stage, people's reactive distress may lead to them being wrongly assumed to have a specific mental disorder.

- The planned exclusion of people with LD/A from MHA section 3 detention has the effect of discriminating against these patients, in removing their eligibility to s.117 aftercare. This is a significant factor that should be mitigated.

- The MCA, including LPS, makes no provision for people deprived of their liberty who lack capacity, but who present a risk to others rather than to themselves; this makes LPS potentially unavailable to protect their rights.

- At the White Paper stage, those responsible for this Bill were reminded that an unforeseen consequence of finding both the MHA and the MCA unavailable might be that people in crisis might face arrest rather than access care. We fear that this issue may also affect older people with dementia.

Detention in inappropriate settings

- Built into the current draft Bill is the internal inconsistency that autism is not a mental disorder within the meaning of the MHA, yet it becomes one if an offence is committed. This urgently requires correction.
- The experience of our members, and, reportedly, of mental health professionals, is that the C(E)TR process needs great improvements, for example in listening to all the different viewpoints including those of care providers.

Additional support and resources to ensure the successful implementation of changes

- A greater focus is needed on the role of the CQC, which urgently needs to improve its relationships with providers and its monitoring procedures. To achieve this Bill's aspirations, the CQC will have to rigorously monitor and address the system-wide barriers to quality care, such as silo working and flawed budget-sharing.
- Without significant support to the wider care sector, including rigorous duties on those responsible for commissioning and providing resources, person-centred and empowering care will remain unachievable.
- For community care to work, commissioners, regulators and the wider multi-disciplinary team, will need to support and enable a stable, confident staff group to acquire new skills where needed.

To what extent do you agree or disagree with the following statements?

a. The draft Mental Health Bill will allow patients to have a greater say in their care.
b. The draft Mental Health Bill will ensure that admissions under the Mental Health Act happen only when strictly necessary.
c. The current law, which treats physical and mental illnesses differently regarding patient consent to treatment, takes the right approach.
d. The draft Mental Health Bill strikes the right balance between increasing patient autonomy and ensuring the safety of patients and others.
e. The draft Mental Health Bill will make it more likely that people with learning disabilities and autistic people will receive appropriate care.
f. The draft Mental Health Bill will address inequalities in the mental health system related to race and ethnicity.
g. The draft Mental Health Bill will ensure that people in prison with acute mental health needs have access to the right treatment.
h. The draft Mental Health Bill will reduce the number of people subject to community treatment orders.
i. The draft Mental Health Bill will achieve its aim of avoiding detention in inappropriate settings.
j. There are appropriate alternative routes to care for those who will no longer be detained under the new rules.

k. The ability to appoint a "nominated person" instead of a "nearest relative" will improve support for detained patients.
l. The proposals to increase the number and frequency of automatic referrals to a Mental Health Tribunal are the right approach.
m. Professionals will need additional support and resources to implement these changes successfully.
n. The third sector will need additional support and resources to support these changes successfully.

3.Is there anything that you'd like to tell us about how you would improve the draft Mental Health Bill? If your answer refers to a specific question above, please include the number of the question in your answer. (500 word maximum)

a & b

1. At the White Paper stage, the Bill was predicated on statutory principles. These reflect current best practice in mental health: experience of the MCA since 2007 has demonstrated the value of statutory principles when considering complex issues. There was widespread support for including these human rights-based principles, and we find their exclusion from the draft Bill disappointing. We would argue strongly for their re-insertion.

2. The draft Bill appears not to recognise that older people with mental disorders, people with ABI, and those with neurological conditions and LDs other than those involving autism also suffer from the problems of resourcing and inappropriate use of detention under the Mental Health Act (MHA). The Bill must, in our view, further consider the holistic effects of the change from deprivation of liberty safeguards (DoLS) to liberty protection safeguards (LPS). This change will reduce the safeguards available to protect the essential rights of people who lack capacity, especially since the LPS will further differentiate between the use of the MHA and the MCA LPS, for both people living with learning disabilities / autism and those with other learning disabilities, acquired brain injury and dementia, by relying on the tricky concept of 'objection.' It has been recognised since the *Bournewood* case that many people may 'object' in non-verbal ways, including by becoming withdrawn or apparently aggressive.

e & j

It has been a matter of concern for many years that considerable numbers of people with learning disabilities end up inappropriately in prison. Hence, the proposal to differentiate access to MHA section 3 between 'civil' patients and those in prison, when diagnosed with similar disorders, appears clearly discriminatory. If enacted, this does nothing to support the essential human rights of a significant proportion of vulnerable people who are wrongly channelled into the criminal justice system.

Care England supports the thrust of these statements and of the Bill, in their aspiration to prevent the ongoing scandal of poor or inappropriate care being provided in mental health hospitals to people who cannot benefit from being there.

However, we are deeply concerned that the legal framework as proposed can only work for the benefit of people with learning disabilities and/or autism – and other conditions as discussed - if the right options are available for their care. This means that flexible, person-centred care provision in the community must be prioritised and resourced. Currently, it is not. Without this, as pointed out at the White Paper stage, people's reactive distress may lead to them being wrongly assumed to have a specific mental disorder.

We note with some disquiet that the planned exclusion of people with learning disabilities and/or autism from MHA section 3 detention has the effect of discriminating against these patients, in removing their eligibility to s.117 aftercare. This is a significant factor that should be mitigated.

i.

1. Built into the current draft Bill is the internal inconsistency that autism is not a mental disorder within the meaning of the MHA, yet it becomes one if an offence is committed. This urgently requires correction.

2. We appreciate the logic of requiring a C(E)TR, to ensure engagement from commissioners and to prevent unnecessarily long stays in hospital. However, the experience of our members, and, reportedly, of mental health professionals, is that the C(E)TR process needs great improvements, for example in listening to all the different viewpoints including those of care providers. We foresee a problem of accountability if forced to follow the recommendations of a C(E)TR. The front-line care provider will carry the legal responsibility for the care provided, without always being properly included in reaching the recommendations.

j.

We are concerned about the legal gap created by the way the division between the use of the MHA and the MCA LPS will work. The MCA, including LPS, makes no provision for people deprived of their liberty who lack capacity, but who present a risk to others rather than to themselves; this makes LPS potentially unavailable to protect their rights.

We note that, at the White Paper stage, those responsible for this Bill were reminded that an unforeseen consequence of finding both the MHA and the MCA unavailable might be that people in crisis might face arrest rather than access care.

We fear that this issue may also affect older people with dementia, noting the recent occasion (June 2022) when a person of 93, living with dementia and with only one leg, was tasered, subdued with a baton, and handcuffed by police.

m.

We would like to see a specific focus on the role of the CQC. It needs urgently to improve its relationships with providers and its monitoring procedures. To achieve this Bill's aspirations,

they will have to rigorously monitor and address the system-wide barriers to quality care, such as silo working and flawed budget-sharing.

m & n

1 We are deeply concerned that the statements in m and n exclude by far the greatest number of providers of adult social care. Without real and significant support to the wider care sector, including rigorous duties on those responsible for commissioning and providing resources, person-centred and empowering care will remain as unachievable as it has evidently been since the exposure of *Winterbourne View*.

2 Some people with learning disabilities have been impossible to manage safely outside hospital given the nature of their condition and the risks arising from their responses to daily life. For community care to work, commissioners, regulators and the wider multi-disciplinary team, will need to support and enable a stable, confident staff group to acquire new skills where needed.

Care England
14 November 2022