The Law Society response to Reforming the Mental Health Act White Paper

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Summary

The Law Society welcomes the publication of the White Paper on Reforming the Mental Health Act and the findings of the Independent Review from 2018. The overhaul of the Mental Health Act ('MHA') is occurring in tandem with changes to the Mental Capacity Act ('MCA'), representing a monumental shift of a highly complex and crucially important legislative landscape, which engages fundamental human rights. It is vital that legislation which governs the deprivation of a person's liberty upholds the rule of law through clear, accessible and proportionate measures which promote autonomy, choice and dignity and a regime which ensures access to justice, allowing people to challenge inappropriate treatment. Solicitors have a vital role in supporting vulnerable people subject to mental health legislation to understand their rights and to access justice.

Upholding the rule of law and access to justice are key concerns for the Law Society in all its work. This summary, highlighting key priorities (with a full list of our recommendations annexed at the end) is framed in line with these core principles, which underpin all areas of our response:

1. Laws must be clear and accessible

Detaining a person under the MHA necessarily engages their human rights. It is therefore of vital importance that the law is clear and eliminates ambiguities.

a) Legislation

As the MHA dates back to 1983, serious caution is required in its overhaul, particularly given the interpretation of the legal concepts that has developed under the current wording of the Act, and others, since then. Changes must be clearly scrutinised and justified in order to ensure that the legislative intent and purpose underpinning this reform is achieved.

We recommend:

- The detention criteria should reference the timing of potential harm as 'imminent', to ensure that the risk is real.
- The word 'safety' should not be included in the detention criteria twice with different contexts, in order to avoid unintentional broadening and confusion in the criteria.
- The word 'welfare' should not be included in the detention criteria, given the scope for confusion as a result of its wide-ranging meaning as a legislative concept in children's law and the lack of definition under the MHA.
- References to 'best interests' should not be included in any provisions where this is not specifically intended to refer to the statutory principle under the MCA.
- Clarity should be provided on the interaction of the proposed Care and Treatment Plans ('CTPs') with the Welsh CTPs under the Mental Health (Wales) Measure 2010.
- S131 of the MHA should be extended to competent under-16s, to provide greater clarity on the parameters of parents' decision-making powers.

- Clarity should be provided on how relevant legislative provisions will be impacted by the proposed ability for competent under-16s assessed to choose their Nominated Person ('NP').
- The proposed power for Independent Mental Health Advocates ('IMHA') to appeal to the tribunal on a patient's behalf should supplement, rather than replace, the patient's own right of appeal.
- Information is provided as to which treatment is intended to fall within Category 2 of the 'new legal framework'.

b) Application in practice

Though the White Paper is intended to precede further consultation, ahead of legislation, clarity is required on how the proposals are envisaged to operate in practice. This is particularly important, given the highly interdependent and complex nature of the mental health system and its interaction with the law, as changes in one area will necessarily impact others.

We recommend further information is provided as to:

- How the amended detention criteria will operate in practice, including relevant approaches to be taken by the tribunal.
- The legal nature of Advance Choice Documents ('ACDs'), including their interaction with the MCA and the role of our members in supporting patients engaging with these documents of legal significance.
- The alternative legislative route which will be used to implement the provision and review of CTPs for all children and young people receiving inpatient care, and timing.
- How long the temporary overruling of a NP is envisaged to last or operate in practice.
- How excluding people with learning disabilities and autistic people from section 3 of the MHA is envisaged to operate in practice, including relevant associated provisions.
- How excluding patients under Part III of the MHA from the amended detention criteria (which we do not support) is envisaged to work in practice, including relevant associated provisions.
- Why proposed changes to the application of the MHA to people with learning disabilities or autism only affect civil patients and not those within the criminal justice system

2. <u>Laws should apply equally to all</u>

People detained under the Mental Health Act are all ultimately in need of therapeutic treatment for mental disorder, whether they pose risk to themselves or others. However, the White Paper draws distinctions between various groups of people, setting a dangerous precedent for differential 'classes' of people in the mental health system.

a) People lacking mental capacity

A person without capacity to make decisions on their own behalf has limited ability and opportunity to challenge such decisions. Therefore, we consider that greater efforts should be made to ensure these people's autonomy is respected where possible when decisions are made on their behalf by others, so that they are able to effectively engage with the law, participate in and challenge decisions affecting them, and access justice on the same basis as others. However, the White Paper seems to provide them with fewer safeguards than people who have capacity.

We recommend:

- More frequent automatic tribunal referrals are urgently implemented prior to legislation, particularly for patients who lack mental capacity and who therefore depend on these hearings for independent oversight and review of their detention.
- Provisions are made to enable another person to apply on behalf of an incapacitated section 2 patient, such as by a Mental Health Act Administrator, IMHA or NP, to enable them to benefit from additional appeal rights as others do.
- Advocacy services are made automatically available on an 'opt out' basis for all patients who lack mental capacity, and that IMHAs can apply to the tribunal on their behalf.
- The timeframe for Second Opinion Appointed Doctor certification under s58 of the MHA applies equivalently to those without the relevant mental capacity or ACD. Specifically, that they are also able to have certification at 14 days, rather than 2 months.

b) People in the criminal justice system

The White Paper proposes arbitrary legal distinctions, listed below, between people who are in the criminal justice system, and those who are not, despite these patients often being treated on the same wards. We are concerned that that this approach will create a distinction between 'civil' patients and those admitted under Part III of the MHA without a clear justification for doing so, resulting in unintended consequences.

We recommend:

- The amended detention criteria should apply to patients under Part III of the MHA, as well as those under Part II.
- The extension of powers for the tribunal should extend to restricted patients under Part III, in order to facilitate progress towards discharge and aid effective access to justice for all people subject to the MHA.

c) People with learning disabilities and autistic people

The proposal to exclude people with learning disabilities and autistic people from s3 of the MHA may have limited practical impact in and of itself. Serious caution is therefore required to ensure that unintended negative consequences do not arise as a result, such as people with learning disabilities and autism simply being detained in hospital under different, and potentially inappropriate, legal frameworks.

We recommend:

- Alternatives to hospitalisation are made available for people with learning disabilities and autistic people.
- A thorough assessment is made of alternative legal frameworks that may apply, including the MCA.
- Appropriate therapeutic accommodation is provided for people with learning disabilities and autistic people who are also in the criminal justice system.

3. Laws should be capable of being enforced

Whilst many of the White Paper's proposals are welcome, we believe that legislative reform alone will not necessarily bring about the changes intended. To make the proposals effective changes are required to the wider context.

a) Resourcing

Without adequate resourcing of the changes and without action to address the underlying causes of the problems, there is a real risk that these necessary reforms will simply fail to deliver.

We would like to draw attention to the following issues:

- The increased role and powers of the Mental Health Tribunal will increase strain on the legal system, necessitating increased funding for the tribunals, legal representatives and advocates. However, people should not be unnecessarily deprived of their liberty as a result of administrative pressures arising out of these changes.
- Improving advocacy services should be made a priority in terms of additional resourcing, to ensure that they can be available on an 'opt-out' basis to all patients.
- The lack of available hospital beds is a barrier to patients receiving the treatment they need, ranging from those waiting in A&E to those requiring secure transfers within a reasonable timeframe.
- The lack of community-based services can result in frequent and unhelpful readmissions.

b) Legal status and authority

Unless the changes are legally enforceable, they may not result in any practical change.

We recommend:

- Government clarifies the legal status of ACDs and the circumstances in which they may be overridden to ensure that the patient's expressed wishes are genuinely given more weight in line with the White Paper's stated aim to provide "enhanced rights for patients who should have a greater say about what happens to them when they are made subject to the Mental Health Act"
- The important role of solicitors in helping clients to prepare such documents is both recognised and funded on a non-means tested basis.
- A clear process for identifying who will take on the role of an interim NP is set out in primary legislation, to ensure appropriate authority.
- The test for assessing Gillick competence is set out in statute and supported by clear guidance for practitioners applying this test. Given the wider implications of this, further consultation may be required.

c) Process

It is important that the changes envisaged by the White Paper are realistically achievable, in order to be effective.

We recommend further consideration is given to:

- How the proposed legislative requirement for all ACDs to be offered to all people who have previously been detained would work in practice.

- The process for creating and approving CTPs, to ensure that these do not become a 'tick-box' exercise, whilst providing patients with vital information about their care as soon as possible.
- Strict monitoring of the effectiveness of the proposed new duty on local commissioners to ensure adequacy of supply of community services for people with a learning disability and autistic people.
- The role of judges in considering appeals regarding treatment decisions, should these focus solely on the process as opposed to clinical decisions, as we recommend. If they can only mandate a reconsideration by the Responsible Clinician, then this may be an ineffective route for patients to challenge their treatment.
- The need for particular additional powers for the tribunal in considering an application by a patient on supervised discharge.

4. Access to justice is necessary for all

It is vitally important that people who are deprived of their liberty can access the courts to challenge the lawfulness of the decision to detain them.

The right to independent judicial oversight of decisions made on a person's behalf, and availability of mechanisms for challenging these decisions, are extremely important. There should be no difference between the right of a person with capacity and an incapacitated patient to access justice nor should those within the criminal justice system be denied access to justice.

We recommend:

- Implementation and resourcing of more frequent automatic referrals to the tribunal are prioritised as a matter of urgency, prior to legislative change. This will especially benefit patients who lack capacity to apply to the tribunal, who can currently wait up to 3 years for any judicial oversight depending on the section they are detained under.
- Patients' existing rights to access justice, including Hospital Managers hearings and revocation of automatic review of decisions to revoke a CTO, are not removed.
- The powers of the Mental Health Tribunal are not reduced in line with the 'approach of First Tier Tribunal (Special Educational Needs and Disability)', as suggested in the White Paper.
- The power to overrule or displace a NP should sit with the Mental Health Tribunal (or Mental Health Review Tribunal in Wales) due to the specialist knowledge and experience of these tribunals and representation is available on a non-means tested basis in line with other proceedings before these tribunals.
- Should the proposed supervised discharge come into force, all patients should have a right of appeal to the tribunal in each period of their detention, regardless of their capacity.
- The Government implement the Criminal Procedure (Capacity) Bill, to align the way that people with mental health difficulties are managed in the Magistrates and Crown Courts.
- Advocacy services are made available on an 'opt out' basis for all patients. We recognise that this must be properly resourced in order to be effective, and so recommend prioritising this first for patients who lack mental capacity, children and young people, and people with learning disabilities and autistic people.

- NPs should be able to make an application to the tribunal on a patient's behalf in the case that a patient does not have or engage with an advocate.

Conclusion

Overall, we welcome the efforts made by the Government in tackling such a complicated area and the Government's aim of reforming the law so that it limits interference with a person's liberty, respects the patient as an individual, including their autonomy, and ensures detention has a therapeutic benefit.

Nevertheless, caution is necessary to ensure that these aims are achieved, and the rule of law is upheld.

We note that several areas were not consulted upon in the White Paper, and consultation on the reforms is anticipated to continue for much of this year. The Law Society looks forward to continuing to provide our expertise to the Government on this important matter, on behalf of our members.

1. Introduction

1.1. The Law Society of England and Wales is the independent professional body that works globally to support and represent 200,000 solicitors, promoting the highest professional standards and the rule of law. We represent the profession to parliament, government and regulatory bodies and have a public interest in the reform of the law. The Law Society is committed to upholding the rule of law and promoting access to justice.

1.2. We welcome the opportunity to respond to this White Paper and the work to reform the Mental Health Act 1983 ('MHA'). When the state intervenes in a person's freedom, for reasons related to their mental health, fundamental safeguards are essential to ensure that this is necessary and proportionate. The law must be clear, fair, capable of being enforced and accessible particularly to those on whom it impacts, as well as for solicitors who play an important in representing and supporting their clients. Those affected must have access to the courts. Whilst many of the White Paper's proposals are welcome, these must be sufficiently backed up by legal authority and resources in order to be effective in practice. The Government has acknowledged that the MHA must be brought into the 21st century[1], and it is vital that this is done properly and that further delay is avoided while vulnerable people continue to be subject to inadequate legislation governing their rights.

1.3. This paper outlines our views on the consultation questions and proposals that we consider important given our remit of upholding the rule of law and access to justice. This is particularly important considering concurrent legal reforms in the mental health sphere, such as the introduction of the Liberty Protection Safeguards.

1.4. Our members working in mental health law, including those who serve on our specialist Mental Health and Disability advisory committee, are uniquely placed to provide insight into the operation of the law and the mental health system, given their independent role in supporting and advising people detained under the MHA. We have been extensively involved in this process, assisting the Advisory Panel for the Independent

[1] https://www.gov.uk/government/speeches/we-must-bring-the-mental-health-act-into-the-21st-century

Review of the MHA in 2017 in deciding which areas of the MHA required legislative attention. Given the broad legal expertise of our members, the Law Society is well positioned to further consider these changes in a wider legislative context, such as in relation to children's law.

1.5. We note that the consultation process is expected to continue over the coming months, ahead of future legislation and we note the lack of questions within the paper on certain areas such as children and young people, and key findings of the Independent Review, such as the over-representation of people from ethnic minority groups within the mental health system, which we hope will be addressed.

1.6. Furthermore, we would like to emphasise the importance of ensuring that reforms are consistent across England and Wales. Without this, serious cross-border issues are likely to arise.

2. Clearer, stronger detention criteria

(Consultation questions 2 and 2a)

We want to change the detention criteria so that detention must provide a therapeutic benefit to the individual. Do you agree or disagree with this proposal? Please give reasons for your answer.

2.1. The Law Society strongly agrees with this proposal, as this would better reflect human rights standards. Detention must be necessary and proportionate, used as a measure of last resort and with care provided in the least restrictive setting. In order to achieve this, legislative clarity is essential.

2.2. The MHA should be updated in line with Rooman[2], specifically regarding the "*therapeutic aspect of detention in accordance with Article 5 § 1 (e), i.e. to recognise explicitly that there exists an obligation on the authorities to ensure appropriate and individualised therapy*".[3]

2.3. The court determined that '*any detention of mentally ill persons must have a therapeutic purpose, aimed specifically, and in so far as possible, at curing or alleviating their mental-health condition, including, where appropriate, bringing about a reduction in or control over their dangerousness"*.[4]

2.4. The current accompanying Code of Practice to the MHA ('Code') is clear that, 'simply detaining someone, even in a hospital, does not constitute medical treatment.'[5] Therefore, to link detention to therapeutic benefit, there must be beneficial treatment available for the patient which cannot be delivered without detention. We support the overarching purpose of comprehensive Care and Treatment Plans to fully justify any detention as well as to give proper consideration of the patient's wishes and preferences.

(Consultation questions 3 and 3a)

[2] Rooman V Belgium European Court of Human Rights (Grand Chamber) [2019] ECHR 105, paragraph 205.
[3] Rooman V Belgium European Court of Human Rights (Grand Chamber) [2019] ECHR 105, paragraph 208.
[4] Rooman V Belgium European Court of Human Rights (Grand Chamber) [2019] ECHR 105, paragraph 208.
[5] Mental Health Act Code of Practice, Paragraph 23.18

We also want to change the detention criteria so that an individual is only detained if there is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person. Do you agree or disagree with this change?
Please give reasons for your answer.

2.5. The law must be clear in order to be applied consistently and fairly. This is especially important when the law permits interference with a person's fundamental human rights, as under the MHA. The Law Society has further comments on this proposal below, but above all considers legislative clarity of critical importance.

2.6. The Detention Criteria Topic Group of the Independent Review of the MHA was asked to consider whether the 'current risk thresholds' were the right ones, as well as how to support positive risk-taking and 'standardised/operationalised risk assessment'. Risk is not explicitly mentioned in the current criteria for detention.

2.7. The Topic Group recommended that an individual should only be detained if - 'there is a significant likelihood of imminent harm to the health, safety or welfare of the person, or the safety of any other person'.[6]

2.8. We find that the Government's proposed wording – 'substantial likelihood of significant harm' - omits the consideration that the timing of significant harm is important, resulting in the possibility of longer detention. If timing is not included, there is a real risk of patients being detained for prolonged periods due to historical harm, i.e. assaults from several years ago which were significant and potentially connected to a mental disorder and therefore could be said to satisfy a 'substantial likelihood'.

2.9. The requirement that the harm is imminent (i.e. is about to happen/impending) would ensure that the detention is only required because of a real current risk, as opposed to a perceived future risk.

2.10. The White Paper states that the risk of harm posed by an individual must be 'evidenced and recorded, encouraging professionals to focus on more than the individual's presenting behaviour and the perceived likelihood and severity of the harm', with a requirement to 'document the specific risk that justifies detention and how detention will deliver therapeutic benefit' in the new statutory Care and Treatment Plan.'

2.11. It is not clear how this substantial risk of significant harm is to be evidenced and recorded. For example, it is not specified whether Historical Clinical and Risk Management ('HCR-20') assessments would be required in all cases, whether a patient would have had to commit 'serious harm' before it could be recorded, or what type of harm is covered, such as psychological.

2.12. The Law Society considers that the inclusion of 'imminent harm' would lead to a much clearer test, through which risk of harm necessitating detention could be more accurately demonstrated. We therefore recommend the wording, *'there is a*

[6] Independent Review of the Mental Health Act 1983: supporting documents, p128 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778898/Independent_Review_of_the_Mental_Health_Act_1983_-_supporting_documents.pdf

substantial likelihood of significant imminent harm', to be used in the first part of the detention criteria.

2.13. We agree that at the point of detention there is a need for an assessment of the risk of harm posed by an individual. However, the potential harm of not detaining the patient must be balanced against the potential harm of detention and forced treatment. This should be made clear in the criteria to ensure a consideration of proportionality and minimise unnecessary detentions.

2.14. We agree with the topic group's recommendation that 'the Code and forms should require that practitioners demonstrate how they have assessed the potential benefits and harms of detention, other non-compulsory interventions which might mitigate risk, and how they have been informed by the voice of the patient'.[7]

Welfare

2.15. The criteria for depriving a person of their liberty must be tightly and narrowly drawn. It is our view that the word 'welfare' should be removed from the proposed criteria. We consider it to be vague, there is a lack of clear justification for inclusion and it potentially results in unintended consequences, such as broader detention criteria. We believe that reference to 'welfare' is confusing, as it has a different meaning in practice to 'health and safety' of a person, thus widening the criteria without clarity as to what this means.

2.16. There is no statutory definition of 'welfare' in the current Act or Code. However, the MHA references it in relation to the displacement of a Nearest Relative[8] and Guardianship.[9] Jones has considered the latter use as 'wide enough to encompass the need to prevent the patient's welfare being prejudiced at some point in the future'.[10] Such abstract concepts, including the possibility of some harm occurring at an unspecified point in the future, seem directly contrary to the Government's stated intention of establishing 'clearer, stronger' detention criteria.

2.17. Furthermore, there are significant risks of confusion with the meaning of 'welfare' in other legislation. In children's law, 'welfare' is a very distinct concept, as the 'paramount consideration' for the court when deciding matters relating to children.[11] It is extremely broad, including factors such as 'physical, emotional and educational needs'[12], and is used interchangeably with the 'best interests of the child'.[13]

2.18. Accordingly, we are seriously concerned that inclusion of the term 'welfare' is likely to widen, not tighten, the detention criteria as well as be legislatively confusing, particularly for children. We recommend this word is removed from the proposed detention criteria to ensure legal clarity.

Safety of any other person

[7] Ibid, p132
[8] s29(2)(d) MHA 1983
[9] s27(2)(b) MHA 1982
[10] Richard Jones, *Mental Health Act Manual* (23rd edition, Sweet and Maxwell 2020), p1-142

[11] s1 Children's Act 1989
[12] s3 Children's Act 1989
[13] *Re M (children) (Ultra-Orthodox Judaism: Transgender) (Stonewall Equality Ltd and another intervening) - [2018] 3 All ER 316]*

2.19. We do not understand the reason for proposing to change 'protection of other persons' to 'safety of any other person'. Paragraph 14.9 of the current Code sets out the factors to be considered in deciding whether patients should be detained for their own health or safety, including risk of suicide, self-harm and self-neglect as well as the individual's inability to look after their own safety. To apply such factors in relation to 'any other person' would unintentionally widen the detention criteria, potentially making it easier to detain a person based upon another person's perception of their or another's safety.

2.20. Additionally, to use the word safety within the criteria twice, with different connotations, would be misleading and confusing. We therefore recommend that the current wording is maintained to avoid implying a broader or different meaning and ensure legal clarity.

Application in practice

a) Test of dangerousness

2.21. The White Paper states that, 'the new detention criteria will need to be applied (inter alia) when a patient's case is brought before the Mental Health Tribunal'. Clarification is required on whether the proposed new criteria would apply when the Nearest Relative ('NR') or Nominated Person ('NP') applies for the patient's discharge and appeals to the Mental Health Tribunal if the discharge is barred.[14]

2.22. At present the additional test to be applied by the tribunal in these applications is, 'that the patient if released/discharged would be likely to act in a manner dangerous to other persons or to himself'.[15] We question whether it is proposed that the test of dangerousness remains for NP applications.

b) Part III patients: application of the new detention criteria

2.23. The Law Society considers that that the amended detention criteria should apply to Part III patients as well as those under Part II. Patients detained under both Parts are often treated on the same ward and applying different criteria to a certain set of patients would result in a new threshold for one class of patients over another.

2.24. The White Paper states that patients under Part III have a 'unique risk profile which must be carefully managed', and to change the criteria for them would 'limit the scope for professional discretion or judgment with regard to risk, and therefore compromise our ability to adequately protect the public from risk of harm from sometimes serious or violent offenders'.

2.25. The suggestion that the reformed criteria will not apply to Part III patients, to ensure that it does not make it harder for those subject to the criminal justice system to access the care and treatment they need is in our view misguided.

2.26. Although patients detained under Part II may not have been prosecuted for a criminal offence, they may have a long history of violent behaviour, with equivalent or higher risk levels than a patient under Part III. This is therefore an unhelpful, artificial and unjustified distinction between two categories of people.

2.27. We consider that applying our proposed detention criteria to all patients detained under the Act will ensure equal treatment between those who have and have not committed

[14] MHA, s66(1)(g)
[15] MHA, s72(1)(b)(iii)

a criminal offence but still require treatment, with a therapeutic benefit, for mental disorder.

c) Part III patients: discharge on Community Treatment Orders

2.28. Applying different detention criteria for Part II and III patients would also result in contradictions regarding patients discharged on a s17A Community Treatment Order ('CTO'), as a CTO is available to both Part II and III (s37 and s41(5) only) patients. The current criteria apply to s3 (Part II) and s37 (Part III) patients.

2.29. Whilst the White Paper proposes changes to the statutory criteria for sections 2, 3 and CTOs, it does not address detention under s37. This will mean that if a s3 patient is discharged onto a CTO, it would be under the same threshold criteria under which they were detained. However, if a s37 patient were discharged there would be two different criteria to meet, one for the original detention under s37 (for which there is no proposal to change): and one for the discharge onto the CTO, for which it is proposed that the criteria be changed. This demonstrates the impractical consequences of drawing arbitrary distinctions.

d) Part III patients: recall criteria of patients on CTOs

2.30. The White Paper states the intention to revise these criteria is to reflect the 'wider changes around detention criteria'. If the proposal is not to change the detention criteria for Part III patients, then they would be recalled under different criteria, contrary to the White Paper's intention that 'recall will only be possible when it is needed because there is otherwise a substantial risk of significant harm.'

2.31. Although the Law Society cannot speak for mental health professionals, we envisage that there would be practical difficulties and confusion for Community Mental Health Teams in managing patients in the community subject to CTOs with different criteria, thus undermining the effectiveness of the law.

3. Giving patients more rights to challenge detention

(Consultation questions 4 and 4a)

Do you agree or disagree with the proposed timetable for automatic referrals to the Mental Health Tribunal?

- **Patients on a section 3**
- **Patients on a community treatment order (CTO)**
- **Patients subject to Part 3**
- **Patients on a conditional discharge**

Please give reasons for your answer.

3.1. It is vitally important that people who are deprived of their liberty can access the courts to challenge the lawfulness of the decision made to detain them. We therefore agree with the proposed timetables for automatic referrals for the categories of patients outlined in this question. In addition, we consider that implementation and resourcing of these proposals should be prioritised as a matter of urgency prior to legislative change, as opposed to being 'phased in' as suggested in the White Paper.

3.2. When assessing resourcing for the tribunal, the need to fund legal representatives and Independent Mental Health Advocates ('IMHA') must be factored in also, as important parts of the legal system tasked with delivering these proposals.

3.3. We strongly urge the Government to immediately reduce the time period for automatic referrals, particularly to benefit patients who lack capacity to appeal to a tribunal. These patients' vulnerability presently renders them unable to access justice in between automatic referrals, which may take up to 3 years depending on the section that they are detained under, thus resulting in them being detained for far longer than may be necessary.

Patients on a section 2

3.4. At present, if a patient lacks capacity to apply for a tribunal hearing, they must wait for automatic referrals to take place. Whilst increasing the number of automatic referrals will help this cohort in general, we consider that additional provisions for s2 patients are required.

3.5. Although the plan to extend the right of appeal for patients detained under s2 beyond the first 14 days is positive, it will not benefit patients who lack capacity. This is because apart from an appeal by the patient, there are no other mechanisms for their case being able to be heard before the tribunal. Specifically, there are no provisions for an IMHA or NP to refer these cases to a tribunal during the section.

3.6. Furthermore, the provision[16] for the Secretary of State to refer to the tribunal the case of a patient detained under Part II of the Act at any time does not assist patients who lack capacity as they lack the necessary capacity to instruct a solicitor to ask for the referral.

3.7. We believe that provision should be made to enable another person to apply on behalf of an incapacitated s2 patient, such as by a Mental Health Act Administrator, IMHA or NP. It is our view that there must be a right for a s2 patient's case to come before the tribunal, additional to automatic referrals, if they lack capacity.

3.8. We also support an extension of the right to appeal from 14 to 21 days, in particular as the proposal is that the care and treatment plan should be developed at least at the 14 day stage and it might be that the patient would wish to appeal their section given the content of that plan.

3.9. The tribunal must be sufficiently resourced in order to be able to respond to this increased volume of applications, and to be able to list them within 7 days of receipt. In April 2020, the Law Society argued against a proposal to extend this time frame to 7 working days (i.e 10 days), as it would unjustifiably lengthen the potential amount of time that a person is detained against their will for administrative reasons.[17] The extension was brought into force due to the COVID-19 pandemic, but we consider that the original position should be reinstated as soon as possible, as patients should

[16] s67 MHA 1983

[17] This was a consultation by the Tribunal Procedure Committee. No decision had been made prior to the short-term position of extending the listing via the Coronavirus Act legislation.

not be subject to further restrictions on their liberty only to ease the administrative process of the tribunal.

Patients on a section 3

3.10. In respect of patients detained under s3, we note that the Government accepts the review's proposal to reduce the initial maximum detention period under s3 to 3 months, and for renewals to take place at 3 months, 6 months and yearly thereafter.

3.11. The White Paper proposes automatic referrals to the tribunal at 4 months, 12 months and yearly thereafter if the patient has not appealed. Whilst this proposal does not mirror the new renewal periods, we agree with the additional reviews proposed, as having regular reviews will benefit patients who lack capacity to appeal to the tribunal and ensure their cases are heard. Furthermore, if the proposal to abolish Hospital Manager's hearings is passed (which we do not support), we are of the view that the tribunal will play an even more important part in reviewing the renewal of a patient's detention.

3.12. Ahead of tribunal hearings, we agree that the Responsible Clinician ('RC') should certify that the patient continues to meet the detention criteria. However, we suggest that the timeframe for this is amended to 7 days in advance of the hearing, as opposed to 10, for this legal requirement to be most effective. Clarity is also required on whether this, or a modified version, is proposed for s2 or CTO patients.

Patients on a Community Treatment Order

3.13. We agree with the proposed provisions for referral to the tribunal, which mirror the renewal of detention. However, the same issues we have raised in relation to patients who lack capacity apply to this cohort, requiring a mechanism allowing another person to apply to the tribunal on their behalf.

Patients subject to Part III

3.14. The Law Society considers that referrals should be every 12 months, linked to the renewal of the section and the fact that the detention must provide therapeutic benefit. A patient with capacity and an incapacitated patient should have the same right to a hearing, and therefore our recommendation for someone else to be able to exercise that right on behalf of the patient, as outlined above, is also applicable here.

3.15. Some patients in this category may not wish to participate in such hearings, and consideration should be given to paper reviews if the patient has capacity to consent and has received legal advice. If a case is dealt with by way of a paper review it could be considered by a single judge, who retains the ability to decide for whatever reason that an oral hearing is required, and the matter could then be listed, as is the current situation with CTO paper reviews.

Patients on a conditional discharge

3.16. We agree with automatic referrals being introduced for these patients. If the new supervised discharge provisions come into force, then a review by the tribunal every 12 months would mirror the provisions of the Deprivation of Liberty Safeguards ('DoLS') / Liberty Protection Safeguards ('LPS'), which are for a maximum of 12 months each period.

Changes to the tribunal's responsibilities

(Consultation question 5 and 5a)

We want to remove the automatic referral to a tribunal received by service users when their community treatment order is revoked. Do you agree or disagree with this proposal?

Please give reasons for your answer.

3.17. We disagree with this proposal. As the revocation of a CTO necessitates the patient's deprivation of liberty, such patients should be entitled to access justice via independent review of this decision by the tribunal as soon as possible.

3.18. However, we recognise that in a number of cases, the patient is discharged onto a CTO by the time the tribunal is heard. In only these circumstances would we agree that the automatic tribunal hearing could fall away on the basis that the revocation which stimulated the hearing has fallen away. The patient would still be entitled to appeal their CTO.

3.19. If the patient remains in hospital at the time of the hearing, the hearing should proceed to allow the patient to be able to promptly challenge their detention. If automatic referrals were removed as proposed, the patient would have to make their own application to review the section and have to wait for a hearing date in several weeks' time, rather than benefiting from the automatically listed hearing date as soon as possible. If they lack capacity, then they would have to wait for the renewal of the section for an automatic referral. We therefore consider this proposal to negatively impact a patient's existing rights to access justice.

Giving the Tribunal more power to grant leave, transfers and community services

(Consultation questions 6 and 6a)

We want to give the Mental Health Tribunal more power to grant leave, transfers and community services. We propose that health and local authorities should be given 5 weeks to deliver on directions made by the Mental Health Tribunal. Do you agree or disagree that this is an appropriate amount of time?

Please give reasons for your answer.

3.20. The Law Society supports the extension of powers for the tribunal, but we believe that these should extend to restricted patients under Part III, in order to facilitate progress towards discharge and aid effective access to justice for all people subject to the MHA.

3.21. The Review's Tribunal, Hospital Managers and Renewals topic group recommended this, after hearing from members of the judiciary and lawyers that they would like the tribunal to be able to direct transfer and leave of absence.[18] This would help patients

[18] Independent Review of the Mental Health Act 1983: supporting documents, p200 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778898/Independent_Review_of_the_Mental_Health_Act_1983_-_supporting_documents.pdf

move towards discharge, for example, by enabling a patient to be tried out on leave before their next application, if not discharged.

3.22. We have no objection to the proposed timeframe in this question. However, in terms of delivery, it is necessary for the tribunal to have sufficient powers to further consider the case in the event of the direction not being complied with, in order for such proposals to be effective in practice.

Restricted patients

3.23. At present, if the Ministry of Justice ('MoJ') declines to grant leave for a restricted patient, there are no procedures to enable leave other than to reapply at a later date, which can take several months. To enable the tribunal to grant leave in such circumstances would facilitate both the patient's progress and their discharge on a future date, allowing a patient to be tried and tested in a community setting with appropriate conditions. This decision would be made by a panel of three experienced professionals, who would only exercise such a power if it was appropriate to do so after hearing all the evidence.

3.24. We do not consider the exclusion of restricted patients justifiable, as it is practically possible for the tribunal to make such directions. For example, consideration could be given to requiring the legal representative to inform the tribunal prior to the hearing (on form CMR1) that they will making an application for a direction so that the RC is asked to complete some questions on leave. The tribunal could therefore access information such as previous leave / applications, and the views of the team, prior to the hearing. Consideration could also be given to the tribunal issuing a Practice Direction ('PD') or guidance on evidence to be required from the RC in considering such a request.

3.25. PDs or guidance could also address any potential difficulties in the ability to grant transfers should there be a lack of evidence as to available options, by requiring parties to provide a report to the tribunal addressing the specific issue. For example, should a hospital not be willing to accept the patient, information supplied could include whether/which hospitals have been approached, relevant catchment areas and the views of the team. This could also apply to the proposed power to direct services within the community.

3.26. We therefore consider that to exclude restricted patients from this proposed extension of the tribunal's powers is drawing an arbitrary distinction between people subject to the MHA. As well as impacting access to justice, this proposal may also result in unintended consequences, negatively affecting the practical application of the law.

First Tier Tribunal (Special Educational Needs and Disability)

3.27. The White Paper suggests that the new powers will align the tribunal with that of the First Tier Tribunal (Special Educational Needs and Disability) ('SEND tribunal'). It is unclear whether this is a reference to the powers of the SEND tribunal to make orders in respect of special educational provision, or the (more recent) power of the SEND tribunal to make recommendations in respect of a child or young person's

health or social care which are part of a "National Trial".[19] Clarification is thus required.

3.28. We have assumed that the reference relates to the former for the purposes of this response but in any event, we do not consider the powers are aligned for the following reasons:

- The SEND tribunal does not 'direct' services in the community which then gives rise to an obligation on health and local authorities to follow. Instead, it directs amendments to be made to a child or young person's Education, Health and Care Plan ('EHC Plan') which the local authority must carry out within a specified timeframe.

- Once the amendments are made to the EHC Plan, if the provision set out in Section F of the EHC Plan is not secured by the local authority, this will be a breach of s42 Children and Families Act 2014, the remedy for which is either a formal complaint to the local authority, or judicial review. There is no requirement or indeed ability to refer the matter back to the tribunal to provide an explanation under any circumstances.

- The duty under s42 is not subject to any sort of 'reasonable endeavours' type of defence – it is an absolute duty.

- The SEND tribunal does not have any enforcement powers. The SEND18 form '"*Carry out our order in special educational needs cases" a parents' guide to what happens now'* explains, 'Once we have issued our decision, we cannot take any further action. We have no power to supervise how and when the order is carried out. Even if the local authority does not do what has been ordered within the time limit, we cannot take further action. You would need to pursue this with the Department for Education'.

3.29. These SEND tribunal powers must be distinguished from the current powers the Mental Health Tribunal has, which are that if a recommendation is made in an unrestricted case for leave or transfer, in the event of any such recommendation not being complied with, the tribunal can direct position statements from the relevant parties and can reconvene to further consider the case.

3.30. We therefore submit that if the proposal is that the Mental Health Tribunal is given the power to grant transfer and direct services within the community, then it must be given power to further consider the case in the event of the direction not being complied with. If not, this will reduce the tribunal's current powers, which seems contrary to the White Paper's intention.

[19] Pursuant to the Special Educational Needs and Disability (First-tier Tribunal Recommendations Power) Regulations 2017

4. Hospital mangers' hearings

(Consultation questions 7 and 7a)

Do you agree or disagree with the proposal to remove the role of the managers' panel in reviewing a patient's case for discharge from detention or a community treatment order?

Please give reasons for your answer.

4.1. The Law Society does not agree with this proposal. Whilst recognising the resource implications for RC's in additional tribunal hearings, we consider that reducing existing opportunities for patients to challenge their detention runs counter to the overall intentions of the White Paper.

4.2. The Code states that Hospital Managers may undertake a review of whether the patient should be discharged at any time, and of course, must review on every renewal and may also review when the RC bars a NR order for discharge.[20] As a patient has only one appeal to the tribunal in each period of detention, if for example in their second 12-month period of a s3 order, the patient appeals in the first couple of months and is unsuccessful, their only way of challenging their detention over the next 9 months is to apply to the Hospital Managers. We do not agree with removing a patient's existing right to access to justice, especially without clear rationale.

5. Strengthening the patient's right to choose and refuse treatment

5.1. We note that this part of the White Paper sets out several proposals consistent with the new overarching principle of "choice and autonomy – ensuring service users' views and choices are respected". We strongly agree with the aim of giving patients greater influence over decisions about their care and treatment, and for their voice to be heard and respected, with the opportunity to challenge when it is not. Our members have an important role to play in supporting patients throughout such processes.

5.2. However, we have concerns that the proposals would fail to deliver this objective, potentially resulting in false expectations for patients without delivering any real change or benefits, whilst simultaneously increasing the administrative burden. The disconnect between what the proposals envisage and the realistic impacts of these may result in serious strain on the mental health system, impacting our members in their ability to uphold the rule of law and support their clients in accessing justice.

Advance Choice Documents

(Consultation question 8, answer also covering questions 9/9a)

Do you have any other suggestions for what should be included in a person's advance choice document?

[20] MHA Code of Practice, chapter 38 'Hospital managers' discharge power', page 385 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

5.3. The Law Society strongly supports the aim of introducing Advance Choice Documents ('ACDs') to enable patients to have a greater role in decisions made about their treatment. Whilst the proposed content and test for validity seems appropriate, we have serious concerns about their documentation and implementation.

5.4. Without robust mechanisms for implementation and enforcement, there is no guarantee that these important documents will enable decisions to be made which can be properly relied on in practice, rendering them largely ineffective.

Legal status

5.5. The White Paper does not explicitly clarify the legal status and corresponding weight that an ACD will have. Despite numerous references to 'legal requirements'[21] in connection with ACDs throughout, it would appear that the intention is that they will not be legally binding. This is confusing and may be misleading, and we recommend that the purpose and effect of an ACD is made plain.

5.6. The requirement for ACDs to be 'considered' by decision-makers is a low and opaque threshold, which may not effectively equate to respecting a patient's wishes. This calls into question the entire purpose of such documents, as the 'legal requirements' referenced may in practice simply be rhetoric, and therefore not enhance the position of the service user in any meaningful way.

5.7. The White Paper proposes that for an ACD to be 'valid and have legal effect, it must have been made by someone who had the relevant capacity and apply to the treatment in question', stating that 'this is the same approach as under the MCA.'

5.8. An Advance Decision to Refuse Treatment is legally binding under the MCA[22] in that it cannot be overridden by a court if the person had capacity to make it, which does not seem to be envisaged for ACDs. As an ACD will combine both advance decisions to refuse treatment (which will not be legally binding), and advance statements for MCA purposes, there is scope for confusion. Clarity is therefore required as to the legal status of ACDs, and regarding their interaction with the MCA.

Preparation of an ACD

5.9. The White Paper says that where possible, ACDs 'should be written with support and guidance from an individual's clinician and other trusted health professionals.' It further suggests that the powers available to IMHAs will be extended to support individuals in preparing ACDs, which may result in confusion for the patient, with cross-over into the roles of the NP and legal representative. Further information is therefore required as to the remit of these roles in relation to the ACD, which must be made available to the individual, who should have the final choice over their support in this process.

5.10. Individuals must be appropriately supported in completing ACDs for them to be sufficiently clear, certain and to have the best chance of applying to, and surviving

[21] For example, the paper states that 'it will be a legal requirement that ACDs are considered when a patient's care and treatment plan is developed', 'decision makers are legally required to consider the advance wishes of a patient', and that ACDs will have 'real power over the decisions and appeals regarding care and treatment'.
[22] Unless they relate to medical treatment for mental disorder being administered under the MHA, in which case they are not.

challenge in, future scenarios. Many people may be unaware of the options available to them, such as treatment options for various issues that could theoretically arise, and what impact on their legal rights this would have in practice, which solicitors can explain in an accessible and independent way.

5.11. Given the purported legal nature of these 'important documents', we consider it imperative that people can access professional legal advice in preparing them. It is necessary to ensure that those engaging with the law can properly understand their rights, the implications of their choices, and their options to access justice if these are not respected in line with the law. We recommend that the important role of solicitors is prioritised and made explicitly clear in relation to ACDs, with the provision of non-means tested legal aid.

5.12. The White Paper intends to ensure ACDs are 'available via a secure digital database'. Individuals must understand how to access or change their ACD if needed, and their personal data must be stored securely.

5.13. Furthermore, it is unclear how awareness will be raised in relation to ACDs, or how the proposed legislative requirement for ACDs to be offered to all people who have previously been detained would work in practice. Members have suggested options such as pro-actively informing patients when they are in hospital for medical procedures. For example, this could include those related to pregnancy, particularly given the high correlation with associated mental health difficulties 'which frequently go unrecognised and untreated'.[23]

5.14. Similarly, the intention to set out in guidance that anyone 'who is at risk of detention' should be offered the opportunity to make an ACD is vague and does not specify whose responsibility this would be, thus requiring further clarity.

Making care and treatment plans statutory

(Consultation question 10)

Do you have any other suggestions for what should be included in a person's care and treatment plans?

5.15. The Law Society strongly welcomes the aim of supporting and respecting a patient's choice and autonomy in Care and Treatment Plans ('CTPs'), as is in place in Wales. It is also important for patients to be provided with information relating to their detention as soon as reasonably possible, in order to be able to effectively challenge decisions, and access justice if needed.

5.16. However, for CTPs to be effective, the practical constraints that mental health professionals encounter must be factored into the process, otherwise they could become a 'tick-box' exercise in practice, thereby undermining their effectiveness and the rights created by the new legal requirements.

Content

5.17. Though the content proposed seems comprehensive, it could potentially set unrealistic expectations for the patient, such as requiring an estimated discharge

[23] National Institute of Clinical Excellence: https://www.nice.org.uk/guidance/CG192/chapter/introduction

date when it may be the case that none can be provided at the time due to limited information. Whilst the White Paper says the CTP should be a 'living document, subject to continued dialogue', this may be difficult to ensure in practice.

5.18. Additionally, the Mental Health (Wales) Measure 2010 sets out requirements for CTPs in Wales, covering eight specified areas, including accommodation, medical and other forms of treatment including psychological interventions, and finance and money, with 'outcomes to be achieved' in at least one of these areas. There is also a section which sets out the services to be provided, relevant dates and who is responsible for providing them.

5.19. The White Paper's proposals for content of CTPs does not explicitly reference these areas, or the Welsh plans. There is scope for confusion if CTPs in England are to differ, and so greater clarity is required.

Process

5.20. Whilst emphasising the importance of patients receiving information about their care as soon as is possible when detained in hospital, we believe that there is scope for further consultation on the process. In particular, regarding timeframes proposed for CTPs to be made and requirement for approval by Clinical or Medical directors (of which there is just one per hospital).

5.21. Instead of mandating entire plans to be approved within a short time frame, which could amount to CTPs becoming nothing more than tick-box exercises effectively being 'rubber stamped', we suggest that certain vital information could be mandated within a short time frame, such as an overview of proposed treatment, with further information required to be added in and approved later on. This would prioritise the patient receiving the most important information relating to their detention, whilst ensuring it is of a high quality.

5.22. Our concerns about the effectiveness of these plans are further exacerbated by the RC's ability to depart from the patient's wishes, and to override treatment refusals with documentary justification and procedural compliance.

5.23. We further welcome the White Paper's confirmation that CTPs will be provided to and regularly reviewed for all children and young people receiving inpatient care, regardless of whether they are detained under the MHA.

5.24. However, we note that the intention is to implement this recommendation by an 'alternative legislative route, rather than through the Act'. We would welcome early provision of further details of this legislation, including its intended timing, to ensure that all relevant stakeholders are aware of this significant development. It would also be helpful if the requirements for such plans were included in the information provided to under-18s, their families, legal representatives and advocates, to ensure that under-18s understand their rights to a CTP.

6. A new framework for patient consent and refusal of medical treatment

6.1. The White Paper does not clearly set out what treatment is intended to fall within Category 2 of the 'new legal framework'. As the proposals are difficult to consider or prepare for in an abstract context, further information is required.

(Consultation questions 11 and 11a)

Do you agree or disagree that patients with capacity who are refusing treatment should have the right to have their wishes respected even if the treatment is considered immediately necessary to alleviate serious suffering?
Please give reasons for your answer.

6.2. The White Paper appears to propose more safeguards for a person's wishes and preferences if that person has capacity than if they do not. This is concerning given that a person without capacity has less ability and opportunity to challenge such decisions and is therefore presumably in greater need of safeguards.

6.3. For example, in Category 2, a person without capacity to consent, who hasn't refused the treatment via a valid ACD, could be given non-urgent treatment with the authorisation of a Second Opinion Appointed Doctor ('SOAD'). In contrast, a person with capacity or an ACD refusing treatment could be treated only if the RC has two medical opinions supporting their application and approval from the court, which is a very onerous process.

6.4. For Category 3 treatments, the proposal to bring forward the point at which a SOAD must certify the decision to override a patient's refusal of treatment from 3 months to day 14 of detention, when their CTP has been signed off by the Clinical or Medical Director, is welcome.[24]

6.5. However, this will only apply to patients who have capacity, or those without it who have previously set out their refusal in an ACD. There is no clear rationale for why the same reduction in time should not apply to patients who lack the relevant capacity, but who have not made a relevant ACD, and specifically why they should have certification at 2 months rather than 14 days.

6.6. We submit that this clearly places people with impaired capacity at a disadvantage, given the lower level of scrutiny they would otherwise receive, along with their lack of equivalent rights in appealing to the tribunal.

6.7. We do not consider this difference in approach justifiable, and so recommend that the timeframe for SOAD certification under s58 of the MHA applies equivalently to those without the relevant mental capacity.

[24] This is in recognition of our earlier points relating to unrealistic timeframes for such approval.

(*Consultation questions 12 and 12a)*

Do you agree or disagree that in addition to the power to require the responsible clinician to reconsider treatment decisions, the Mental Health Tribunal judge (sitting alone) should also be able to order that a specific treatment is not given? Please give reasons for your answer.

6.8. The Law Society endorses the need for a proper route to challenge treatments, independent of medical professionals, as a matter of access to justice. However, we have concerns that this proposal would not deliver this.

6.9. This proposal seems similar to judicial review processes, for example, in having a 'permission to appeal' stage, unlike other tribunal applications. However, it does not set out clear grounds or framework.

6.10. The White Paper emphasises that judges would not take any role in clinical decision-making in such scenarios, and the purpose of hearings is to determine whether appropriate processes have been used by the RC in overruling the patient's decision, and therefore whether this decision – essentially, the treatment - is justified and appropriate. We agree that it is inappropriate for single lay (non-medical) judge to have a role in clinical decision-making.

6.11. If the appeal is intended only to consider the process, this must be made explicitly clear. However, we believe that this may provide very limited routes of redress in practice for patients when they are unhappy with the decision reached, particularly if the outcome is simply a referral back to the RC for them to reconsider their decision. This would provide no concrete outcome for the patient and could very possibly amount to a waste of resources for everybody involved.

7. Improving support for people who are detained

Nominated person

(Consultation questions 13 and 13a)

Do you agree or disagree with the proposed additional powers of the nominated person?

Please give reasons for your answer.

7.1. The Law Society welcomes the replacement of the outdated Nearest Relative ('NR') provisions with the role of the Nominated Person ('NP'). However, legal clarity is required to ensure that this is effective in practice.

'Best interests'

7.2. The reference to an additional power of the NP to object to the use of a CTO if it is in the 'best interests' of the patient is highly problematic, given the 'best interests' statutory principle under the MCA. It may wrongly suggest that this would only apply to those patients lacking capacity and/or that the NP could only object if such a decision was deemed to be in the patient's best interests.

Appointment of interim NPs

7.3. The Law Society considers this role of such importance, not least as the White Paper proposes expanding it, that the process for identifying who will take on the role for a person unable to select their own NP must be set out in primary legislation. This is as opposed to within the Code as proposed, which we consider would be more suitable for supplementary guidance.

7.4. It is critical that legislation sets out a clear process for identification of the interim NP to ensure there is no room for Approved Mental Health Professionals ('AMHP') to doubt the legal basis and process for making this decision.

Overruling of NP

7.5. The power temporarily to overrule rather than remove a NP, should the AMHP disagree with the exercise of their power to block admission when a person is detained, is positive.

7.6. However, the White Paper does not clarify how long such temporary overruling is envisaged to last, or how it would operate in practice, or set out any rights of appeal.

7.7. The Law Society supports the power to overrule or displace a NP to sit with the Mental Health Tribunal (or Mental Health Review Tribunal in Wales) due to the specialist knowledge and experience of these tribunals, in contrast to the Country Court. We also strongly recommend that representation in such proceedings is funded on a non-means tested basis, in line with other tribunal proceedings as identified in the White Paper, as an access to justice matter.

NP role in practice

7.8. It is unclear at what intervals the NP's right to be consulted on CTPs would be activated, as these are intended to be 'living documents' subject to ongoing adaption. Clarity should also be provided on how the patient can identify other individuals who can receive information about their care and treatment.

7.9. Similarly, clarity is needed on the effect and outcome of a NP's objection to, for example, a proposal to transfer to another hospital and/or to renew the patient's detention or CTO.

7.10. The White Paper introduces the ability for patients to challenge a specific treatment through the tribunal. If a patient lacks capacity, their NP can bring this challenge on their behalf, providing that the patient has a relevant and valid ACD. It seems arbitrary that the exercising of this right of the NP is dependent on the presence of a valid ACD.

(Consultation questions 14 and 14a, answer also covering proposals in relation to children and young people)

Do you agree or disagree that someone under the age of 16 should be able to choose a nominated person (including someone who does not have parental responsibility for them), where they have the ability to understand the decision (known as 'Gillick competence')?
Please give reasons for your answer.

7.11. As this is the only consultation question specific to people under the age of 18, we answer this below and then raise wider points in relation to the impact of the proposed reforms on children and young people.

'Gillick' competent children to choose their NP

7.12. The Law Society agrees with this proposal in principle, in that under-18s, should like adults, be able to choose their NP. However, the implications of this proposal require careful consideration for the reasons set out below. These points are relevant to both under-16s and young people aged 16 and 17 years old.[25]

Legal clarity

7.13. Currently, the MHA makes specific provision for the NR where the child or young person is subject to a care order[26], has a guardian appointed under the Children Act 1989 or is living with someone under a Child Arrangement Order.[27] Clarity is therefore needed on how these proposals are intended to impact on these provisions, or whether they will be abolished.

7.14. Furthermore, we suggest that clarity is required regarding unaccompanied asylum seeker children, where the LA is invariably acting as corporate parent under s20 of the Children Act 1989 due to a lack of any other person with parental responsibility.

Provision of information

7.15. It is extremely important that professionals ensure that when under-18s are making decisions about the NP, they are fully informed about the role, including any associated powers and limitations. While everybody should receive clear and accessible information about the NP, this will be particularly important for children and young people, given the extensive powers of the NP and that these will run alongside those of parents and others who have parental responsibility.

Gillick competence

[25] Although under the Children Act 1989, all those under age 18 are considered children, as noted by the MHA Code, it is necessary to distinguish between under 16 (referred to in this documents as 'children'), and 16- and 17-year olds (referred to as 'young people'), to reflect that these two age groups are treated differently in important aspects of this area of law.

[26] Where an under 18-year old is subject to a care order, the NR is the local authority (unless they are married or in a civil partnership), s27 MHA 1983.

[27] s28 MHA 1983, specifically: the person(s) named on a CAO as being the persons with whom the under 18-year old is to live with will be the NR, and the person(s) named as the child's guardian / special guardian under a special guardianship order is the NR.

7.16. Clear guidance will be required for practitioners on the assessment of under-16s' competence to choose their NP. We have provided further comments on Gillick competence below.

Additional views of the Law Society on the proposals relating to children and young people

Decision-making and the role of parents

7.17. To achieve greater clarity on the parameters of parents' decision-making powers we suggest that s131 of the MHA be extended to competent under-16s. Currently, s131 provides that 16- and 17-year olds with capacity can consent or refuse their admission, and their decisions cannot be overridden by parental consent. Such an amendment is supported by the recent case of *AB v CD and Others,* in which in Mrs Justice Lieven concluded that 'the parents' right to consent to treatment on behalf of the child continues even when the child is *Gillick* competent to make the decision, save where the parents are seeking to override the decision of the child'.[28] It should also be noted that the Code advises against relying on parental consent to override a competent child's refusal.[29]

Discharge planning

7.18. We welcome the White Paper's clarification that children or young people admitted to a mental health facility will automatically be considered "in need", and that guidance[30] is to be amended to reflect this. We suggest that such guidance is also included in the Code to ensure that those working in inpatient facilities are aware of under 18s' status as a 'child in need' and that it is necessary that they should make a referral to children's social care.

Safeguards

7.19. We welcome the White Paper's commitment to providing further guidance to improve the safeguards for children and young people admitted to hospital for psychiatric care. However, we suggest the following actions are also needed:

a) Admission to adult wards

7.20. We are disappointed that the Government has not accepted the MHA Review's recommendation that the Care Quality Commission ('CQC') should be notified within 24 hours of a child or young person being admitted to an adult ward (rather than the current notification period of 48 hours), and that the CQC should record the reasons for placement and its proposed length. We believe this should be reconsidered. The purpose of s131A of the MHA is to prevent the inappropriate admission of under-18s to adult psychiatric wards, and the CQC has an important role in monitoring the implementation of this provision.

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[28] *AB v CD and Others* [2021] EWHC 741 (Fam) para 14.i

[29] MHA Code of Practice, paragraph 19.39. We suggest that such an amendment would not affect the provision of treatment to under 18s in life saving emergencies as noted in the Code (paras 19.71-19.72)

[30] see: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2 'Working Together to Safeguard Children', Department for Education

7.21. Data[31] shows that admissions of under-18s to adult psychiatric wards continue, and contrary to Government policy[32], this includes under-16s. Furthermore, given that the admission of under-18s on to adult psychiatric wards raises significant safeguarding concerns, we consider that the current notification period of 48 hours is too long to wait before the CQC is notified. It is only upon such notification that the CQC will be able to take action to ensure that the under-18-year-old is being kept safe and that necessary steps are taken to find a more appropriate placement as swiftly as possible.

b) Notifications to local authorities

7.22. Whilst we welcome the commitment that the Code will make clear that local authorities should be notified when a child or young person is placed out of area, admitted to an adult ward, or their admission lasts more than 28 days, we recommend that consideration is given to including this in legislation, with guidance for local authorities included in the Code. This would be similar to the duty imposed by sections 85 and 86 of the Children Act 1989.[33]

7.23. The purpose of such a provision would be to ensure that local authorities are made aware that the child or young person has been placed out of area or admitted to an adult psychiatric ward, so the local authority can take an active role in addressing any concerns and be involved in the planning of the child or young person's discharge. This is particularly important when children or young people are placed far away from their home, given the difficulty in planning for discharge, which can result in inappropriate unnecessary prolongation of inpatient care.

7.24. We also recommend that the Code make clear that local authorities have a continuing duty to looked-after children, including those who were accommodated by the local authority under s20 of the Children Act 1989 prior to being admitted to hospital.[34]

c) Gillick Competence

7.25. We note that the Government does not accept the Review's recommendation to incorporate a formal test into the MHA, stating that this is a matter for the Code. Whilst recognising that Gillick competence is applicable to a wide range of issues (extending far beyond the MHA), given the White Paper's emphasis on individual's ability to make decisions for themselves, we consider that statutory incorporation of a test for competence is both necessary and justified. This should be supported by clear guidance for practitioners applying this test.

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[31] See: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics/performance-december-2020-provisional-january-2021 (under 16s 'bed days on adult wards' is shown in MHS24a (55); for 16 year olds see MHS24b (21) and for 17 year olds see MHS24c (163).

[32] MHA Code of Practice, paragraph19.97

[33] Under sections 85 and 86 where under 18s have been accommodated in certain establishments, including hospitals for three months or more, the relevant local authority must be notified and upon notification the LA must take steps to determine whether the child or young person's welfare is adequately safeguarded and whether further action is required.

[34] See for example *Re T (children)* [2014] Case No BB13P00548 [2014] Lexis citation 190

7.26. The assessment of competence is essential because the law assumes that under-16s are unable to make decisions for themselves, in contrast to the presumption of capacity for those over 16. We consider that setting out a test in the Act is necessary to ensure that those working with under-16s have a clear and consistent understanding of how to assess competence, thereby supporting under-16s in exercising their rights.

7.27. Given the wider implications of incorporating a test for competence into legislation, this may require further consultation, to ensure that it is aligned with other areas of law. Such a consultation would also be helpful to raise practitioners' awareness of recent case law[35] on how to assess competence (by adapting the functional test set out in s3 MCA).

8. Advocacy

(Consultation questions 15 and 15a)

Do you agree with the proposed additional powers of independent mental health advocates?

Please give reasons for your answer.

8.1. The Law Society welcomes the planned expansion of this role, and the proposal to extend the right to an IMHA to all patients, which will bring arrangements in England into line with Wales.

8.2. We recognise that to be effective, such services must be properly resourced. However, we consider that advocacy should be prioritised as an 'opt out' right for people with learning disabilities and autistic people, in addition to the below groups:

- **Patients who lack capacity**

8.3. Patients who lack capacity to request an advocate are unable to benefit from this vitally important safeguard and so are at a grave disadvantage. We consider that they will be further disenfranchised if advocacy remains available only to those with the capacity to ask for this help. This is important for a range of decisions, not least the power of the IMHA to challenge a treatment decision on such a patient's behalf as discussed earlier in this response.

- **Children and young people**

8.4. Advocacy is also critical for under-18s to be able to understand their legal rights. We therefore welcome the commitment to expand advocacy to all patients, including informal patients and confirmation that the IMHAs training needs will be considered. The right to an IMHA who has the appropriate skills and knowledge will be of particular importance to under-18s, whether or not detained under the MHA. We consider that all under-18s should have automatic advocacy, with an ability to opt out.

Extension of pilot projects on advocacy

8.5. There is further scope to address how advocacy can best support groups of patients with specific needs or sensitivities, such as such as children and young people,

[35] See *Re S (child as parent: adoption: consent)* [2017] EWHC 2729 (Fam)

people with learning disabilities and autism, older people, or those who are LGTBQI+. The pilot proposed by the White Paper on cultural sensitivity could be extended to these groups, who may require advocates with specialised knowledge in order to benefit equally from this important legal safeguard.

Clarity over respective roles in relation to proposed additional powers to appeal

8.6. The proposal for IMHAs to be able to appeal to the tribunal on the patient's behalf is welcome providing that it is in addition to, and not instead of, the patient's own right of appeal; this requires clarification. The White Paper also does not make clear whether this would be for patients lacking capacity or for all patients.

8.7. The Review's Tribunals, Hospital Managers and Renewals Topic Group recommended that insofar as possible, mental incapacity should not be a bar to bringing proceedings before the tribunal (as it is not, for instance, in relation to making a bail application).[36] For this reason, they recommended that IMHAs and nominated persons should be empowered and required to bring applications on behalf of a patient who does not apply where there is reason to believe that they wish to do so,[37] which we strongly support.

8.8. Furthermore, there appears to be no parallel proposal to increase the right of a NP (as recommended by the Review) to make an application in similar circumstances, which we suggest is followed, in the case that a patient does not have or engage with an advocate.

(Consultation questions 16 and 16a)

Do you agree or disagree that advocacy services could be improved by:

- **enhanced standards**
- **regulation**
- **enhanced accreditation**
- **none of the above, but by other means**

Please give reasons for your answer.

8.9. The Law Society strongly agrees that enhanced standards and regulation could improve the overall quality of advocacy services. This would provide accountability, consistency and a structured framework, which we suggest could be in place nationally for the operation of IMHAs in hospitals, benefiting national and bespoke providers.

8.10. Members have reported that the current system and availability of IMHAs varies in different parts of the country. To ensure that all patients have access to an IMHA we support the recommendation of the Review (subject to resourcing and prioritising as

[36] Independent Review of the Mental Health Act 1983: supporting documents, p128 Page 202 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778898/Independent_Review_of_the_Mental_Health_Act_1983_-_supporting_documents.pdf

[37] Review Supporting Docs: p201

outlined above) to 'make advocacy opt out for all who have a statutory right to it, learning lessons from existing best practice including outreach models'.[38]

8.11. However, we recognise this will require an increase in funding, and therefore recommend that certain groups are urgently prioritised as discussed above, with an aim to expand this to all patients as soon as possible. We consider that this should be prioritised by the Government given the critical benefits that IMHAs offer to patients, and the real risk that the service will simply fail to deliver on these necessary reforms without adequate resourcing.

8.12. Regular monitoring will also be necessary, which may require the CQC to inspect access to IMHA provision, as was also recommended by the Review.[39]

8.13. We also believe enhanced accreditation could assist advocates, promote further training opportunities, for example in specialist areas appropriate to certain groups of people, and encourage others to train as advocates.

9. The interface between the Mental Health Act and the Mental Capacity Act

(Consultation question 17)

How should the legal framework define the dividing line between the Mental Health Act and the Mental Capacity Act so that patients may be made subject to the powers which most appropriately meet their circumstances?

9.1. The MCA stands alongside, but in principle is entirely distinct from, the MHA. However, both provide legal means by which people can be deprived of their liberty, and a key interface arises where an individual lacks capacity to decide whether to be admitted to hospital for the purposes of receiving care and treatment for mental disorder. The factors influencing a decision to use either Act must be considered specific to an individual.

9.2. The law connecting these two Acts is complex and each is supported by separate Codes of Practice. The Law Society considers that the lack of clarity on how to determine the relevant application of the MHA or MCA gives rise to significant inconsistency in practice. Proposals for reform relating to both Acts are also running concurrently, which is arguably exacerbating uncertainty in this area.

Inappropriate use of the MCA due to a lack of knowledge

9.3. Members have reported inappropriate use of the MCA relating to a wide range of people who lack capacity and have mental health needs. This largely seems due to a lack of knowledge by medical staff and is especially concerning given the under-use of a law that offers important protections for vulnerable people.

[38] Recommendation 23, Modernising the Mental Health Act: increasing choice, reducing compulsion. See: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf

[39] ibid

Specific areas of concern raised by members include:

Admission to hospital

9.4. There seems to be a lack of understanding regarding the MCA, particularly as seen in health settings, with capacity assessments not being carried out upon admission to hospital. Although this is likely to be due to the urgency of the situation and a lack of specialist knowledge, it means that an increasing number of patients without capacity are being admitted informally, and as a result, being deprived of the protection of either Act

Psychiatric wards

9.5. Members have reported that hospital staff have sometimes been unaware if a capacity assessment has been conducted, with a formal capacity assessment which concludes a lack of capacity often not being conducted until discharge is envisaged.

9.6. This may worsen with the introduction of the LPS which will transfer responsibilities for identifying and authorising a deprivation of liberty in an NHS hospital to the hospital managers, with no involvement from local authorities (who currently have responsibility for all Standard Authorisations for DoLS).

Over reliance on the MCA

9.7. Our members have reported an over-reliance on the MCA in practice, which can impact safeguards, and cause delays or a failure to meet a patient's clinical mental health needs in an appropriate therapeutic environment. We feel that this is particularly relevant for patients and families of those with autism and learning disabilities, and young people, and the elderly in residential care.

9.8. The MCA can sometimes be more assistance to the patient than the MHA, particularly when considering discharging from detention where tribunal powers in this area are more limited. However, whilst in theory, the MCA may be thought to be 'least restrictive', there are concerns in practice that the inappropriate use of the MCA over the MHA is affording a large cohort of people less protection than they require or would otherwise receive.

9.9. Members have reported general distrust of the MHA amongst patients, families and practitioners, who seek to avoid detention under the MHA and would prefer to make use of the MCA.

9.10. Nevertheless, it is important to highlight the lack of safeguards available under the MCA which are offered by the MHA, including:

- No right to an Independent Mental Health Advocate (including the additional aspects of this role as proposed by the White Paper),
- No automatic referrals of their deprivation of liberty to a tribunal,
- No joint duty on CCGs and local authorities to provide s117 aftercare (free of charge),

- No rights for their nearest relative / nominated person to block their admission, apply to discharge them, or the proposed additional prospects to this role as proposed by the White Paper,
- No SOAD review of their treatment, and
- No statutory discharge planning.

9.11. Although the White Paper's aims regarding statutory care planning and increased focus on the patient are welcome, the legislative intent will be ineffective if specialist mental health services are insufficiently resourced. This is relevant for both community and acute settings, but particularly the latter.

9.12. We feel that the lack of specialist provisions for people with autism and learning disabilities, young people and children, and elderly people in residential care is of fundamental importance to these issues. As evidenced by the White Paper, these groups have specific needs which an appropriate legal framework should support, but is in our view, not a standalone answer in and of itself.

9.13. In summary, the Law Society considers that the MHA should be used where appropriate for patients who lack capacity and require admission to a psychiatric unit. However, as the interplay between the two Acts is currently confusing and poorly understood this requires further consultation and careful analysis, especially in light of the proposed legislative changes to both frameworks.

(Consultation questions 18 and 18a)

Do you agree or disagree that the right to give advance consent to informal admission to a mental health hospital should be set out in the Mental Health Act (MHA) and the MHA code of practice to make clear the availability of this right to individuals?

If agree, are there any safeguards that should be put in place to ensure that an individual's advance consent to admission is appropriately followed?

Please provide reasons for your answer.

9.14. The Law Society is concerned by this proposal, as we are unaware of any example of the law of consent working in the way described by the White Paper. We are troubled by the concept of 'advance consent', both in principle and in practice, given the reduced safeguards offered by informal admissions, and the possibility of inappropriate informal admissions that are in reality detentions, and so do not benefit from the safeguards provided by the MHA. Clarity is therefore required, without which we strongly disagree that this should be set out in the Act or Code as it stands.

9.15. In principle, consent is a matter of voluntarily making an informed decision, with capacity to do so, and from clear, available options. This means consideration of what is actually contemplated, what it involves, and what aspects of it (risks and benefits) are most important to that patient as an individual, at that time.[40] It is inherently 'advance' in that it is in anticipation of something concrete that has not yet happened, as opposed to an abstract concept.

[40] Montgomery v Lanarkshire Health Board (Scotland), [2015] UKSC 11

9.16. For example, in physical healthcare, a patient may consent to surgery and post-operative care when they are under anaesthesia, prior to their regaining capacity to make ongoing decisions for themselves. This would be limited and specific, with full comprehension of the situation. We do not consider this comparable to a patient being asked to consent in advance to a blanket possible future informal MHA admission, in any number of unpredictable scenarios.

9.17. Where an individual indicates a willingness to have a specific treatment in the future, this cannot bind them as an Advance Decision to Refuse Treatment under the MCA can, as they cannot compel an option for treatment to be made available to them. They could therefore not bind themselves in future by 'advanced consent', but should they lose capacity, such previous indications would usually be a strong factor in a 'best interests' decision on behalf of that patient should the situation arise.

9.18. In practice, we would be concerned by informal admissions of people based on a previous abstract notion of 'consent', without being fully informed as to what this would mean. This is particularly concerning if individuals are not consenting in reality, at the time of the informal admission and so require detention under the MHA, but are 'bound' by their previous 'consent'. Such patients would be without the essential safeguards and scrutiny provided by the MHA for such detentions, which is very concerning.

9.19. We feel that it is very unlikely that such a proposal would be realistically accepted by the majority of patients who have a full understanding about what this means. If the benefit of such a proposal would be that a patient risks future detention without the protection of the MHA, on the basis that they are a consenting informal patient when in fact (at the time of admission) they are not, the incentive for doing so is unclear.

9.20. Until these points are addressed, the Law Society considers that the lesser safeguards that an informal patient who consents to admission receives are only appropriate where a patient is actually consenting to this at the time in question, which cannot be consented to in advance.

(Consultation questions 19 and 19a)

We want to ensure that health professionals are able to temporarily hold individuals in A&E when they are in crisis and need a mental health assessment, but are trying to leave A&E.

Do you think that the amendments to section 4B of the Mental Capacity Act achieve this objective, or should we also extend section 5 of the Mental Health Act (MHA)?

Please give reasons for your answer.

9.21. As section 4B of the MCA (even in its amended form) will exclude those patients who have capacity and those who are under age 16, the Law Society agrees that an additional power akin to section 5 of the MHA is required to provide this safeguard to all people as needed. However, our support for extending the use of section 5 of the MHA to A&E ('the A&E holding power') is subject to the following:

Clarity on who can exercise such powers

9.22. We agree with the White Paper that these powers 'should only be available to senior clinicians to ensure that they are only used when it is absolutely appropriate'. To ensure this legal clarity, we suggest that the amendment to section 5 specifies who can exercise this power in an A&E setting. Whereas s5(2) permits the doctor or approved clinician in charge of the patient's treatment to delegate their 'doctor's holding power' to a nominated deputy (often a junior doctor), such powers of delegation should not be possible in relation to the A&E holding power.

Limitation of the duration of the A&E holding power

9.23. We consider that if introduced, the A&E holding power should be limited to a period of 24 hours (which cannot be renewed). Providing a power to hold individuals in A&E for 72 hours (3 days) which is the period of detention under section 5(2) of the MHA (the doctor's 'holding power') would be too long. A&E staff should not be expected to manage and support people experiencing mental health crises, in the challenging environment of A&E, while mental health assessments are being arranged, when they are unlikely to be mental health professionals with the necessary skills and experience.

9.24. Limiting the A&E holding power to 24 hours reflects the current period of detention in a place of safety under section 135 or section 136 of the MHA.

Provision of appropriate and specialised therapeutic environment

9.25. It is imperative that alongside any amendment to permit the use of a holding power in A&E, legislation also clarifies that those subject to such powers are placed in an appropriate and specialised therapeutic environment to await a mental health assessment.

9.26. This aligns with the view of the CQC, who recently found that, 'in emergency departments, patients were not always provided with a safe, therapeutic environment. Every emergency department in acute hospitals should have a dedicated room that is equipped to provide a safe and private environment for psychiatric assessments.'[41]

The need to address delays in finding a mental health bed

9.27. While the A&E holding power is proposed as a means of facilitating a mental health assessment it should be noted that another significant concern is the delay in finding a mental health bed for individuals who are assessed as requiring hospital admission. The CQC notes that unavailability of a mental health bed 'is one of the most common reasons for patients waiting longer than 12 hours from the decision to admit them to actually being admitted to an inpatient bed'.[42] Such delays must also be addressed.

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[41] *How are people's mental health needs met in acute hospitals, and how can this be improved?* (CQC 2020 report)

[42] *How are people's mental health needs met in acute hospitals, and how can this be improved? (CQC 2020 report).* The report found that 'at one hospital, the incident list for the emergency department showed that in

10. Caring for patients in the Criminal Justice System

(Consultation questions 20 and 20a)

To speed up the transfer from prison or immigration removal centres (IRCs) to mental health inpatient settings, we want to introduce a 28-day time limit. Do any further safeguards need to be in place before we can implement a statutory time limit for secure transfers?

Please give reasons for your answer.

10.1. We support the proposal for a 28-day time limit for secure transfers, in that this would concentrate minds on the necessity for quick transfers, assessments and bed availability, in line with legislative intent. Despite the establishment of the Court Liaison and Diversion Service, the number of people with mental health and learning disabilities within the prison estate remains a serious problem, as highlighted by the White Paper.

10.2. Addressing the underlying causes of this is vital in order to ensure the proposals are effective in practice and realistically achievable. Our members inform us that these include a lack of available beds, particularly in secure placements, (which we understand is predominantly problematic within London) and transfer recommendations to Psychiatric Intensive Care Units by visiting prison consultant psychiatrists being blocked by the Ministry of Justice in favour of medium secure units.

10.3. We have long considered changes are necessary within the Magistrates and Crown Courts to align the way that people with mental health difficulties are managed in both Courts. We raised these issues in 2011 and 2014 in response to the Law Commission's consultation on 'Unfitness to plead', prior to the final report which was published in 2016.[43] We therefore strongly urge the Government to implement the Criminal Procedure (Capacity) Bill[44], which would bring in the Law Commission's recommendations.

(Consultation questions 21 and 21a)

We want to establish a new designated role for a person to manage the process of transferring people from prison or an immigration removal centre (IRC) to hospital when they require inpatient treatment for their mental health.

Which of the following options do you think is the most effective approach to achieving this?

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the previous 12 months, 24 patients waited more than five hours for a bed, 15 of whom waited more than 12 hours. We have written to NHS England to alert them to this finding and other areas of concern.'

[43] https://www.lawcom.gov.uk/project/unfitness-to-plead/

[44] http://www.lawcom.gov.uk/app/uploads/2016/01/lc364_unfitness_vol-2.pdf

- **expanding the existing approved mental health professional (AMHP) role in the community so that they are also responsible for managing prison or IRC transfers**
- **creating a new role within NHS England and Improvement (NHSEI) or across NHSEI and Her Majesty's Prison and Probation Service to manage the prison or IRC transfer process**
- **an alternative approach (please specify)**

Please give reasons for your answer.

10.4. The Law Society considers that 'creating a new role within NHS England and Improvement ('NHSEI') or across NHSEI and Her Majesty's Prison and Probation Service to manage the prison or IRC transfer process' would be the most effective approach, by senior appointment.

10.5. We do not support the proposal for an AMHP to play such an important role of this kind, given their lack of relevant expertise, knowledge or experience working in the criminal justice system, which could result in issues in practice.

(Consultation questions 23 and 23a)

For restricted patients who are no longer therapeutically benefiting from detention in hospital, but whose risk could only be managed safely in the community with continuous supervision, we think it should be possible to discharge these patients into the community with conditions that amount to a deprivation of liberty.

Do you agree or disagree that this is the best way of enabling these patients to move from hospital into the community?

(Strongly agree – agree – disagree – strongly disagree – not sure)
Please give reasons for your answer.

10.6. The Law Society understands that this proposal is an attempt to address the repercussions of the case of MM[45], in which the Supreme Court decided that the tribunal does not have power to impose conditions that would amount to a deprivation of a person's liberty. In essence, a conditionally discharged patient cannot consent to a deprivation of liberty in the community.

There is currently a difference in outcome depending on whether the patient has or lacks capacity to consent to the proposed conditions.

Patients without the capacity to consent:

10.7. To be able to discharge a restricted patient who lacks capacity to consent, the tribunal must find that patient is ready for conditional discharge, and then defer that conditional discharge on the assurance that the required deprivation of liberty is likely to be authorised under the MCA.

Patients with the capacity to consent:

45 Secretary of State for Justice v MM [2018] UKSC 60

10.8. The tribunal cannot authorise a conditional discharge in this way for patients who have capacity. In practice their situation is currently being managed by use of long-term section 17(3) MHA leave, which is far from ideal. The purpose of section 17 MHA leave is to prepare patients for discharge, for example on a community treatment order, or for restricted patients, on conditional discharge. We are aware that there are funding issues with the use of long-term s17(3) leave, in paying for the community accommodation and keeping a bed open and available to the patient on a ward. We believe it is also wholly unsatisfactory from the perspective of the patient.

10.9. The Law Society believes it is important that patients who are deemed to present a risk requiring a level of supervision and control receive necessary support in the least restrictive environment. We recognise that a fix is needed to enable this group of restricted patients to leave hospital when hospital is no longer providing any therapeutic benefit. We can see that the proposal for supervised discharge is such a fix. However, we do have concerns regarding this proposal, which we believe need careful exploration.

10.10. Conditional discharge into a situation which constitutes a deprivation of liberty is a serious interference in a person's article 5 right to liberty. In the MM judgment, Lady Hale referred to the words of Lord Hoffmann in R v Secretary of State for the Home Department, Ex p Simms [2000] 2 AC 115[46]:

"… the principle of legality means that Parliament must squarely confront what it is doing and accept the political cost. Fundamental rights cannot be overridden by general or ambiguous words. This is because there is too great a risk that the full implications of their unqualified meaning may have passed unnoticed in the democratic process. In the absence of express language or necessary implication to the contrary, the courts therefore presume that even the most general words were intended to be subject to the basic rights of the individual."

10.11. We believe that a system which provides for detention in the community, rather than in hospital, by the state, for people with capacity to consent is such a fundamental change to legislation with a radical impact on their rights that it needs thorough debate. We believe that the implications of such a sea change need to be set out clearly and the interference with fundamental freedoms properly explained. We are not sure that the information within the White Paper is adequate for this purpose.

10.12. We note that the White Paper says 'the supervised discharge would be applicable only to restricted patients and available irrespective of decision-making capacity'. We would like to see the same rights and opportunities for restricted patients to move out of hospital and into the community irrespective of the patient's capacity to consent. However, with the available option of discharge under the MCA available in the best interests of patients who lack capacity, we are not clear how the proposed supervised discharge regime would indeed level the playing field. Further clarity is therefore required.

[46] Ibid, paragraph 131

(Consultation questions 24 and 25)

We propose that a 'supervised discharge' order for this group of patients would be subject to annual tribunal review. Do you agree or disagree with the proposed safeguard?

Beyond this, what further safeguards do you think are required?

10.13. We support this proposed safeguard (subject to additional rights to appeal as discussed below), although further clarity is required to ensure that this application is meaningful, with appropriate powers available to the tribunal.

10.14. Should the proposed supervised discharge come into force, then we believe that all patients must have a right of appeal to the tribunal in each period of their detention, with an automatic referral being made if they do not exercise this right. We therefore agree with the White Paper's proposal that a necessary safeguard for patients on supervised discharge must be the right of appeal to a tribunal every year. However, this must be a meaningful application, with appropriate powers available to the tribunal.

10.15. For example, would the tribunal be able to recommend or order trial leave/testing out in the community with a view to supporting a patient on supervised discharge to progress towards conditional discharge or absolute discharge in due course? We suggest that careful consideration is given to the need for particular additional powers for the tribunal considering an application by a patient on supervised discharge. Furthermore, we believe that every effort must be made to scrutinise and monitor the proposed restrictions with a view to reducing all which are not necessary, working towards avoiding a deprivation of liberty wherever possible.

11. People with a learning disability and autistic people

(Consultation questions 26, 26a, 27, 27a, 28, 28a)

Do you:

- **Agree or disagree with the proposed reforms to the way the Mental Health Act applies to people with a learning disability and autistic people?**
- **Agree or disagree that the proposed reforms provide adequate safeguards for people with a learning disability and autistic people when they do not have a co-occurring mental health condition?**
- **Expect that there would be unintended consequences (negative or positive) of the proposals to reform the way the Mental Health Act applies to people with a learning disability and autistic people?**

Please give reasons for your answer.

11.1. We support the White Paper's expressed commitment to 'reducing reliance on specialised inpatient services for people with a learning disability and autistic people'. However, we do not agree that these proposals will necessarily achieve this aim.

Effectiveness in practice

11.2. The proposal to exclude people with learning disabilities and autistic people from the legislative scope of section 3 of the MHA may mean that the numbers of this group of

people who are detained under the MHA is reduced. However, legislative change alone is unlikely to reduce hospital admissions unless alternative community-based services are made available.

11.3. The White Paper appropriately highlights significant failings in the care of people with learning disabilities and autism who have been placed in inpatient units. We believe that the points below require addressing in order to ensure that people with learning disabilities and autistic people are appropriately provided by these legislative changes:

a) Provision of appropriate community-based services

11.4. Legislative exclusion of people with learning disabilities and autistic people does not address the fact that such individuals need appropriate support. To avoid them simply being admitted to hospital through other legislative means, we consider the development of alternative community-based services, focused on the needs of those using such services, is critical. Otherwise, there is a real risk that people with learning disabilities and autism will be inappropriately and disproportionately impacted by the law.

11.5. It is also important that such services do not replicate the problems that have arisen in the current system of in-patient mental health services. To avoid the replication of 'institutional care' within community-based settings, we suggest that appropriate location, environment and staff are considered.

b) Consideration of alternative legal frameworks

11.6. As noted above, we are concerned that unless community-based alternatives to hospital admissions are developed, people with learning disabilities and autistic people will continue to be admitted. However, if they are excluded from section 3 of the MHA, then alternative legal frameworks will be engaged, undermining legislative intent.

11.7. This would presumably be an unintended consequence, in that the only practical change arising from the reforms would be a change in the legal basis for people with learning disabilities and autistic people admission and ongoing care. Simply changing the legal basis for admission and on-going care may do little to improve the experience of, and outcomes for, people with learning disabilities and autistic people.

11.8. We anticipate that the DoLS / LPS will in many cases provide the alternative legal framework under the MCA, bearing in mind the minimum ages (18 and 16 respectively). We have raised concerns about the inappropriate use of the MCA earlier in this response, including the reduced safeguards that it provides compared with the MHA.

11.9. Notwithstanding our concerns about the reduced safeguards, we are aware that many people with learning disabilities, autistic people and their families are concerned about the negative and stigmatising impact of detention under the MHA. We believe that as this debate moves forward, people must be fully informed of any alternatives to detention under the MHA that may apply.

11.10. However, it is also crucial to ensure that legal reform achieves greater safeguards for, and respect for the rights of people with learning disabilities and autistic people. Accordingly, clarity is needed on the consequences of the exclusion provisions in practice.

11.11. A thorough comparison must be made of all possible alternative legal frameworks to the MHA, specifically in relation to safeguards (including the opportunity and ease of appeal against detention and access to legal aid to support that appeal, and the rights of appeal against care and treatment decisions) and entitlements (such as s117 aftercare) under such frameworks.

c) Individuals who object to their hospital admission and/or inpatient care

11.12. Clarity is needed on the situation for people who lack capacity to make decisions about their care arrangements, but who object to being in hospital or their treatment. Currently in such cases the MHA would apply where an application under section 2 or 3 could be made.

11.13. However, if the MHA is amended so that people with learning disabilities and autistic people cannot be admitted under section 3 unless they have a co-occurring mental health condition, it is our understanding that DoLS / LPS would apply, even though the person objects to being accommodated in hospital or any part of their treatment.

d) Risk of repeated detentions under section 2 of the MHA

11.14. The White Paper states that the assessment process under section 2 'should seek to identify the driver of this behaviour' (namely the person being 'so distressed that there is a substantial risk of significant harm to self or others'), whether this is a mental health condition or something else, such as an unmet social care need.

11.15. We question whether it is realistic to assume that the 'driver' for a person's behaviour can always be identified within 28 days, and are therefore concerned that a possible consequence of the exclusion provisions is that people with learning disabilities and autistic people may be subject to repeated admissions for assessment under section 2**.**

(Consultation questions 29 and 29a)

We think that the proposal to change the way that the Mental Health Act applies to people with a learning disability and autistic people should only affect civil patients and not those in the criminal justice system. Do you agree or disagree? Please give reasons for your answer.

11.16. The Law Society disagrees with this proposal. We are concerned that this approach will create a distinction between 'civil' patients and those admitted under Part III of the MHA without a clear justification for doing so, resulting in unintended consequences. If the reason for excluding people with learning disabilities and autistic people who do not have any co-existing mental health condition from long term detention under the MHA is that these conditions are life-long, 'which cannot be removed through treatment', it is not clear why this point is not equally relevant to those involved in the criminal justice system.

11.17. We appreciate that applying the exclusion to Part III would mean that hospital admission would not be available as an alternative to prison, raising the significant concern that prisons are inappropriate environments for people with learning disabilities and autistic people. Accordingly, this highlights the importance of ensuring that the reform of the MHA is undertaken in conjunction with other legal reforms, such as the development of sentencing options that include alternative to prison sentences, alongside the provision of community-based support that focuses on the needs of people with learning disabilities and autistic people.

11.18. Furthermore, it is not clear from the proposals how these changes would affect people with learning disabilities and autistic people who are admitted to hospital under s37 of the MHA (without restrictions under s41). Currently, the MHA provides for such individuals to be discharged from hospital under a CTO. However, if the exclusion provisions apply to the use of a CTO, this would not be possible to those who have learning disabilities and/or are autistic, but do not have a co-existing mental health condition. This in itself could lead to prolonged admissions in hospital, contrary to the principle of least restriction.

11.19. For these reasons we suggest that further consideration is needed to assess the likely impact of these proposed measures on people with learning disabilities and autistic people, taking into account the wider issues relevant to the criminal justice system and the extent to which it accommodates the particular needs of these two groups of people.

(Consultation questions 31 and 31a)

Do you agree or disagree that the proposal that recommendations of a care and treatment review (CTR) for a detained adult or of a care, education and treatment review (CETR) for a detained child should be formally incorporated into a care and treatment plan and responsible clinicians required to explain if recommendations aren't taken forward, will achieve the intended increase compliance with recommendations of a CETR?

Please give reasons for your answer.

11.20. Whilst we agree that it would be helpful for these recommendations to be formally incorporated into a patient's CTP, we question why it is only the RC who would be required to consider the findings and recommendations and explain any deviation from CETR's recommendations.

11.21. Fulfilling any recommendations with the aim of supporting a person's discharge from hospital will necessarily require work and co-operation on the part of a range of agencies, including the local authority, the clinical commissioning group and in some cases, NHS England. The RC is not responsible for putting in place the package of care needed to support a person's return to the community, nor does the RC have access to the resources required to do so.

11.22. Accordingly, we consider that it essential that the requirements placed on the RC to explain why recommendations are not taken forward are also extended to all other relevant agencies, together with a duty on the RC and relevant agencies to collaborate and co-operate in implementing recommendations, enabling effective accountability, oversight and enforcement.

(Consultation questions 32 and 32a)

We propose to create a new duty on local commissioners (NHS and local government) to ensure adequacy of supply of community services for people with a learning disability and autistic people. Do you agree or disagree with this? Please give reasons for your answer.

11.23. We strongly agree with this proposal, welcoming the emphasis on ensuring adequacy of community-based services by local commissioners. However, we believe that there must be strict monitoring of the effectiveness of this duty, and measures to address any failure in its fulfilment.

11.24. Our members report that commissioning failures are often a significant contributory factor to the abuses and injustices experienced by people with learning disabilities and autistic people who may need mental health support. This is linked to the lack of specialist, good quality provision of such services. Currently, when these failures occur, there are limited means of redress, by way of long-winded complaints procedures or prohibitively expensive legal options. Therefore, such duties must be appropriately supported by legal enforcement mechanisms to ensure people can effectively access justice.

(Consultation question 34)

What can be done to overcome any challenges around the use of pooled budgets and reporting on spend on services for people with a learning disability and autistic people?

11.25. The Law Society consider it disappointing that pooled budgets are not used efficiently and effectively for the benefit of people with learning disabilities and/or autistic people. Our members experience this issue arising frequently in the provision of s117 aftercare services, often in the context of arranging appropriate accommodation.

11.26. We welcome the White Paper's statement that national guidance will give 'greater clarity on how budgets and responsibilities should be shared to pay for s117 aftercare' and consider that this guidance requires urgent attention. As the Review noted, the lack of clarity on 'who pays; for what care; in what proportion; and in what locality' causes 'delays to providing care to the most vulnerable people' and results in money 'being diverted away from front-line services and spent on costly legal disputes.'

11.27. Furthermore, we consider that the scope of guidance on s117 should extend to other areas that create barriers to the effective application of this very important joint duty on NHS bodies and social services to provide aftercare services.

11.28. It would be helpful if such guidance explains how to determine which NHS body and local authority is responsible for commissioning and funding s117 aftercare service in

light of case law[47] and the 2020 update of '*Who Pays? Determining responsibility for NHS payments to providers.'*

11.29. The reform of the MHA is an opportunity to provide clarity regarding responsibilities and duties under s117, as well as and bolstering the efficacy of budget-pooling, by introducing independent scrutiny of their use, and sanctions should failures occur.

12. Additional Matters

12.1. We note that the White Paper arose from the report of the Independent Review of the Mental Health Act 1983, published in 2018.[48] As the White Paper was published in January 2021, in the midst of the COVID-19 pandemic, we implore the Department of Health and Social Care to produce an updated Impact Assessment. The full consequences of the ongoing pandemic remain yet to be fully understood, though given the widely documented impacts on mental health[49], strain on the system is to be expected.

12.2. Furthermore, it is vital that the changes are aligned with the framework in Wales, to avoid unnecessary and substantial unintended consequences arising as a result of changes occurring in silos. We also highlight the need for the changes to be aligned with others taking place concurrently in the mental health sphere, including the revision of the Mental Capacity Act Code of Practice and implementation of the Liberty Protection Safeguards.

13. Conclusion

13.1. The Law Society welcomes the opportunity to respond to this White Paper. It is essential that the Government fully consults with stakeholders during the course of this monumental legislative reform, not only because of the highly complex nature of the laws, particularly within a wider legislative landscape, but especially because these laws govern people's fundamental rights to liberty.

13.2. Caution is needed when reforming highly complicated and technical legislation of this type, especially to ensure it upholds the rule of law and ensures access to justice, the importance of which cannot be overstated for people at risk of being detained. People must be able to understand their rights and how to access justice. Our members play a crucial role in this, providing independent support to people detained under mental health legislation, many of whom are extremely vulnerable.

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[47] We note that *R (Worcestershire County Council) v Secretary of State for Health and Social Care* and *Swindon Borough Council) [2021] EWHC 682 (Admin)* has confirmed the basis on which the local authority responsible for a person's aftercare is to be determined, but understand that this decision may be appealed.

[48] Final report of the Independent Review of the Mental Health Act 1983, December 2020. See: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf

[49] Data analysis in November 2020 by Mind revealed that more people experienced a mental health crisis during the COVID-19 pandemic than ever previously recorded. See: https://www.mind.org.uk/news-campaigns/news/mind-warns-of-second-pandemic-as-it-reveals-more-people-in-mental-health-crisis-than-ever-recorded-and-helpline-calls-soar/

13.3. We welcome the intention that there should be minimal interference with people's rights. However, in order to achieve this, changes are needed to the proposed regime. Legislation must be clear and accessible, to ensure it is implemented effectively. There should not be arbitrary distinctions between different classes of people. Moreover, the proposals must be sufficiently supported by legal authority and a well-functioning legal system, with suitable investment to ensure that people's liberty is not placed at risk by reason of a lack of resources in the system. People should have rights to challenge decisions affecting them, and should have the right to support in doing so by solicitors, advocates and others.

13.4. People must be treated equally by the law, regardless of their mental capacity or involvement in the criminal justice system. For the proposals to be effective, those subject to the law must be able to properly access justice, and where their ability to do so is impacted, they should be supported and provided with increased safeguards under the law.

13.5. We look forward to ongoing consultation on the issues we have highlighted in this response and anticipated future changes, and to continuing to provide our expertise to the Government in this work.

14. List of Recommendations

Clearer, stronger detention criteria

- The MHA should be updated in line with Rooman[50], specifically regarding the therapeutic aspect of detention.
- The detention criteria should reference the timing of potential harm as 'imminent', to ensure that the risk is real and current.
- The word 'welfare' should not be included in the detention criteria, given the scope for confusion as a result of its wide-ranging meaning as a legislative concept in children's law and the lack of definition under the MHA.
- The word 'safety' should not be included in the detention criteria to avoid unintentional broadening and confusion.
- 'Protection of other persons' should not be changed to 'safety of any other person' as it widens the criteria
- Clarity should be provided on whether it is proposed that the test of dangerousness remains when a NP applies for the patient's discharge.
- The amended detention criteria should apply to Part III patients as well as those under Part II to avoid creating a new threshold for one class of patients over another.

Giving patients more rights to challenge detention

- Implementation and resourcing of the proposals in relation to more frequent automatic referrals to the tribunal as in consultation question 4 should be prioritised as a matter of urgency, prior to legislative change, as opposed to being 'phased in'.
- When assessing resourcing for the tribunal, the need to fund legal representatives and IMHAs should also be also considered.

[50] Rooman V Belgium European Court of Human Rights (Grand Chamber) [2019] ECHR 105

- Provisions should be made to enable another person to apply to the tribunal on behalf of an incapacitated s2 patient. There must be a right for their case to come before the tribunal, additional to automatic referrals, if they lack capacity.
- The requirement for the tribunal to list applications within 7 days of receipt should be reinstated as soon as possible.
- The timeframe for a RC to certify that a s3 patient meets the detention criteria should be reduced to 7 days instead of 10, for this to be most effective. Clarity should be provided on whether this, or a modified version is proposed for s2 or CTO patients.
- Referrals of patients subject to Part III should be every 12 months, linked to the renewal of the section and the detention must provide therapeutic benefit.
- Consideration should be given to paper reviews if a Part III patient does not wish to participate in their hearing, as long as they have capacity to consent and have received legal advice.
- If the supervised discharge provisions come into force, there should be automatic reviews by the tribunal every 12 months.
- The automatic referral to a tribunal when a CTO is revoked should not be removed.
- Only if the patient is discharged onto a CTO by the time the tribunal is heard, should the automatic tribunal hearing be able to fall away.
- The extension of powers for the Mental Health Tribunal should extend to restricted patients under Part III in order to facilitate progress towards discharge.
- The tribunal should have sufficient powers to further consider the case in the event of proposed new directions not being complied with.
- Clarity should be provided on how the proposed additional powers for the Mental Health Tribunal are envisaged to align with those of the SEND Tribunal, so as to ensure they are not reduced.

Hospital managers' hearings

- The role of the Hospital Managers' panel in reviewing a patient's case for discharge from detention or a CTO should not be removed.

Strengthening the patient's right to choose and refuse treatment

Advance Choice Documents

- Clarity should be provided as to the legal status of ACDs and their interaction with the MCA.
- Further information should be provided as to the remit of the roles of IMHAs, NPs and the legal representative in relation to preparation of an ACD, which must be made available to the individual, who should have the final choice over their support in this process.
- Individuals should be appropriately supported in completing ACDs and able to access professional legal advice.
- The role of solicitors should be prioritised and made explicitly clear in relation to ACDs. Support should be available on a non means-tested basis.
- Individuals should understand how to access or change their ACD if needed, and personal data should be secured safely.
- Clarity should be provided on how the opportunity to make an ACD should be given to anyone 'at risk of detention', and how the proposed legislative requirement for ACDs to be offered to all people who have been previously detained would work in practice.

Care and Treatment Plans

- Clarity should be provided on whether CTPs are to align with those in Wales.
- The practical constraints that mental health professionals encounter should be factored into the process of creating and approving a CTP. Further consultation should be carried out, particularly regarding timeframes and approval requirements by a Clinical or Medical director.
- Certain vital information should be mandated within a short time frame, such as an overview of proposed treatment, with further information required to be added in and approved later on.
- Further details of the alternative legislative route to provide CTPs for all children and young people receiving inpatient care, including timing, should be provided.

A new framework for patient consent and refusal of medical treatment

- Further information should be provided as to what treatment is intended to fall within Category 2 of the 'new legal framework'.
- Safeguards should be prioritised for people without mental capacity to ensure their wishes are respected.
- The timeframe for SOAD certification under s58 of the MHA should apply equivalently to those without the relevant mental capacity.
- A patient should have an effective means of challenging a treatment decision. If the proposal is that a judge sitting alone can only review the process and remit a decision back to the RC for reconsideration, this would provide a very limited form of redress, which may prove unsatisfactory for the patient and a poor use of resources.

Improving support for people who are detained

Nominated Person

- The reference to an additional power of the NP to object to the use of a CTO if it is in the 'best interests' of the patient should be removed, given the 'best interests' statutory principle under the MCA.
- Legislation should set out a clear process for identification of the interim NP to ensure there is no room for AMHPs to doubt the legal basis and process for making this decision.
- Clarity should be provided on how long the temporary overruling of an NP is envisaged to last, or how it would operate in practice, and any rights of appeal.
- The power to overrule or displace a NP should sit with the Mental Health Tribunal (or Mental Health Review Tribunal in Wales), in contrast to the Country Court.
- Representation in such proceedings should be funded on a non-means tested basis, in line with other tribunal proceedings.
- Further information should be provided as to when the NP's right to be consulted on CTPs would be activated, and how the patient can identify other individuals who can receive information about their care and treatment.
- Clarity should be provided on whether the NP's objection to transfers between hospitals, and/or renewals and extensions to the patient's detention or CTO would have any practical effect.
- The ability for NPs to challenge a specific treatment through the tribunal if a person lacks capacity should not depend on the presence of a valid ACD.
- Children assessed to be Gillick competent should be able to choose their NP, however further consideration of the implications for the introduction of the NP for under 18s is required. Clear guidance will be required for practitioners on the assessment of under-

16s' competence to choose their NP.

Children and young people

- Clarity should be provided on how the proposals are intended to impact on current MHA provisions which make specific provision for the NR where the child or young person is subject to a care order[51], has a guardian appointed under the Children Act 1989 or is living with someone under a Child Arrangement Order.[52]
- Clarity should be provided regarding unaccompanied asylum seeker children, where the LA is invariably acting as corporate parent under s20 of the Children Act 1989 due to a lack of any other person with parental responsibility.
- Professionals should ensure that under-18s are fully informed about the role of the NP, and that under 18s receive clear and accessible information.
- S131 of the MHA should be extended to competent under-16s to achieve greater clarity on the parameters of parents' decision-making powers.
- Guidance should be included in the Code to ensure that those working in inpatient facilities are aware of under 18s' status as a 'child in need' and that it is necessary that they should make a referral to children's social care.
- The Care Quality Commission ('CQC') should be notified within 24 hours of a child or young person being admitted to an adult ward (rather than the current notification period of 48 hours), and the CQC should record the reasons for placement and its proposed length.
- Consideration should be made as to including in legislation the requirement for local authorities to be notified when a child or young person is placed out of area, admitted to an adult ward, or their admission lasts more than 28 days, with guidance included in the Code.
- The Code should make clear that local authorities have a continuing duty to looked-after children, including those who were accommodated by the local authority under s20 of the Children Act 1989 prior to being admitted to hospital.[53]
- There should be statutory incorporation of a test for competence, which should be supported by clear guidance. Further consultation should be considered to ensure it is aligned with other areas of law.

Advocacy

- Advocacy services should be prioritised as an 'opt out' right for people with learning disabilities and autistic people, children and young people, and people who lack capacity.
- Advocates of people with specific needs or sensitivities should have specialised knowledge to ensure they are properly supported.
- IMHAs should be able to appeal to the tribunal on the patient's behalf in addition to, and not instead of, the patient's own right of appeal. Clarity is required as to whether this applies to all patients, regardless of capacity.
- Mental incapacity should not be a bar to bringing proceedings before the tribunal. IMHAs and NPs should be empowered and required to bring applications on behalf of a patient who does not apply where there is reason to believe that they wish to do so.

[51] Where an under 18-year old is subject to a care order, the NR is the local authority (unless they are married or in a civil partnership), s27 MHA 1983.

[52] s28 MHA 1983, specifically: the person(s) named on a CAO as being the persons with whom the under 18-year old is to live with will be the NR, and the person(s) named as the child's guardian / special guardian under a special guardianship order is the NR.

[53] See for example *Re T (children)* [2014] Case No BB13P00548 [2014] Lexis citation 190

- Standards and regulation should be enhanced to improve the overall quality of advocacy services.
- Advocacy should be provided on an opt out basis for all those who have a statutory right to it. Increased funding should be prioritised by the Government to ensure this is made available as soon as possible.
- There should be regular monitoring of advocacy services.

The interface between the Mental Health Act and the Mental Capacity Act

- The factors influencing a decision to use either Act must be considered specific to an individual.
- The safeguards offered by the MHA, which are not available under the MCA, should be considered and explained when selecting the most appropriate legal framework for detention.
- Specialist mental health services must be properly resourced in both community and acute settings, particularly for those with specific needs such as elderly people in residential care.
- The MHA should be used where appropriate for patients who lack capacity and require admission to a psychiatric unit but as the interplay between the two Acts is currently confusing and poorly understood this requires further consultation and careful analysis.
- The right to give advance consent to informal admission to a mental health hospital should not be set out in legislation or the Code as it stands, without further clarity being provided.
- An additional power akin to section 5 of the MHA (subject to limitations) is needed to ensure that health professionals can temporarily hold individuals in A&E when they are in crisis and need a mental health assessment, as section 4B will exclude patients who have capacity and are under 16.
- The amendment to section 5 of the MCA should specify who can exercise this power, namely, only senior clinicians.
- The powers of delegation in s5(2) should not be possible in relation to the A&E holding power.
- The A&E holding power should be limited to 24 hours, which should not be able to be renewed.
- Alongside any amendment to permit the use of a holding power in A&E, legislation should also clarify that those subject to such powers are placed in an appropriate and specialised therapeutic environment to await a mental health assessment.

Caring for patients in the Criminal Justice System

- There should be a 28-day time limit for secure transfers. However, the underlying causes of this must be addressed to ensure that the proposals are effective and achievable in practice. Specifically, this relates to a lack of available beds.
- The Government should implement the Criminal Procedure (Capacity) Bill[54], to align the way that people with mental health difficulties are managed in the Magistrates and Crown Courts.
- A new role should be created within NHSEI or across NHSEI and Her Majesty's Prison and Probation Service to manage the prison or IRC transfer process, by senior appointment. This should not be carried out by an AMHP given their lack of relevant expertise.

[54] http://www.lawcom.gov.uk/app/uploads/2016/01/lc364_unfitness_vol-2.pdf

- Patients who are deemed to present a risk requiring a level of supervision and control should receive necessary support in the least restrictive environment. The proposals in relation to supervised discharge may be suitable, but further consideration and thorough debate is required.
- Clarity should be provided as to how supervised discharge is envisaged to interact with the MCA, if a patient lacks capacity to consent.
- Patients subject to a supervised discharge order should have annual tribunal reviews.
- Consideration should be given to the need for particular additional powers for the tribunal considering an application by a patient on supervised discharge.
- Every effort should be made to scrutinise and monitor the proposed restrictions with a view to reducing all which are not necessary, working towards avoiding a deprivation of liberty wherever possible.

People with a learning disability and autistic people

- Further consideration is needed to assess the likely impact of the proposed measures on people with learning disabilities and autistic people, taking into account the wider issues relevant to the criminal justice system and the extent to which it accommodates the particular needs of these two groups of people.
- Alternative community-based services should be made available to ensure that the proposals in relation to people with learning disabilities and autistic people are effective.
- Community-based settings should meet specific needs and properly consider suitable locations, environment and staff.
- People with learning disabilities, autistic people and their families should be fully informed of any alternatives to detention under the MHA that may apply.
- A thorough comparison should be made of all possible alternative legal frameworks to the MHA, specifically in relation to safeguards (including the opportunity and ease of appeal against detention and access to legal aid to support that appeal, and the rights of appeal against care and treatment decisions) and entitlements (such as s117 aftercare) under such frameworks.
- Clarity should be provided on the situation for people who lack capacity to make decisions about their care arrangements, but who object to being in hospital or their treatment.
- If the proposed changes to the way that the MHA applies to people with a learning disability and autistic people are introduced, they should apply to civil patients and to those in the criminal justice system.
- The reform of the MHA should be undertaken in conjunction with other legal reforms, such as the development of sentencing options that include alternative to prison sentences, alongside the provision of community-based support that focuses on the needs of people with learning disabilities and autistic people.
- Further information should be provided on how these changes would affect people with learning disabilities and autistic people who are admitted to hospital under s37 of the MHA (without restrictions under s41).
- The requirements placed on the RC to explain why recommendations are not taken forward should also be extended to all other relevant agencies, together with a duty on the RC and relevant agencies to collaborate and co-operate in implementing recommendations, enabling effective accountability, oversight and enforcement.

- There should be strict monitoring of the effectiveness of the proposed duty on local commissioners to ensure adequacy of supply of community services for people with a learning disability and autistic people.
- Such duties should be appropriately supported by legal enforcement mechanisms.
- The scope of guidance on s117 should extend to other areas that create barriers to the effective application of the joint duty on NHS bodies and social services to provide aftercare services.
- Guidance should explain how to determine which NHS body and local authority is responsible for commissioning and funding s117 aftercare service in light of case law[55] and the 2020 update of '*Who Pays? Determining responsibility for NHS payments to providers.'*
- Independent scrutiny and sanctions of budget-pooling and duties under s117 should be introduced, should failures occur.

Additional Matters

- The Department of Health and Social Care should produce an updated Impact Assessment, especially in light of the COVID-19 pandemic.
- The changes should be aligned with the framework in Wales, to avoid unnecessary and substantial unintended consequences arising as a result of changes occurring in silos.

[55] We note that *R (Worcestershire County Council) v Secretary of State for Health and Social Care* and *Swindon Borough Council) [2021] EWHC 682 (Admin)* has confirmed the basis on which the local authority responsible for a person's aftercare is to be determined, but understand that this decision may be appealed.