

The future of the Mental Health Act

**Institute of Psychiatry, Psychology and
Neuroscience, King's College London**

Dr Gareth Owen

The Policy Institute at King's

Alexandra Pollitt, Dr Benedict Wilkinson
and Laura Jones

Power of Numbers Ltd.

Ross Pow



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About the Policy Institute at King's

The Policy Institute at King's College London addresses complex policy challenges with rigorous research, academic expertise, and analysis focused on improving outcomes. Our vision is to enable the translation of research into policy and practice by facilitating engagement between academic, business and policy communities around current and future issues in the UK and globally.

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About Mental Health and Justice

Mental Health and Justice is a Wellcome-funded collaborative research endeavour spanning psychiatry, law, ethics, neuroscience, social science/public policy and service user involvement. The project takes an interdisciplinary approach to two fundamental duties: the duty to protect people in contexts where they can be vulnerable and the duty to respect their agency and autonomy.

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Summary

In October 2017, Prime Minister Theresa May announced an independent review of the Mental Health Act, chaired by Professor Sir Simon Wessely. Mental health is an increasingly high priority for government and the Mental Health Act (MHA) is a key piece of legislation in this area. Under the Act, people with a mental disorder may formally be:

- detained in hospital against their own wishes in the interests of their own health or safety, or the safety of others.
- treated in the community but subject to recall to hospital when necessary for assessment and/or treatment under a Community Treatment Order (CTO).
- taken to a 'place of safety' (a hospital or a police station) to be assessed for a mental illness.

The review is a significant piece of work for those with an interest in this area, including those who have mental disabilities or disorders, the charities that support them, the professionals working in this area (such as clinicians, social workers and the police) and the lawyers and academics interested in the development of such legislation.

Mental health inhabits a complex policy making space. For much of the history of UK mental health provision, it could be argued that things were slow to change, in terms of the treatments available to patients, the infrastructure and systems set up to provide mental health 'care' and the public attitudes that pervaded the discourse around mental health. That is no longer the case and the rate of change has steadily been increasing. A powerful set of factors now feed into mental health policy deliberations: protecting the rights of the individual; providing parity with physical health; avoiding discrimination; investing in new ways to recover and sustain mental health and well-being.

Neither are the debates around how the law should evolve conducted by relatively small groups of professionals and politicians. In an increasingly connected world, the discussion about mental health policy, more than ever, is played out as a much larger public conversation.

The variety of factors to take into account and the breadth of legitimate perspectives (patients and professionals, politicians and the public), mean that on a number of issues, there are quite diverse ideas on the best way forward. Often different opinions are held by members of the same stakeholder groups and across all contributors, strongly-held views can be passionately expressed.

We should use that energy as an encouragement to keep evolving the law to reflect, as best as possible, the new insights it is possible to create through bringing these perspectives together, rather than seeing them as cause for despair or an excuse to stick with the status quo.

In this spirit and to help inform the debate of how mental health law might evolve, in November 2017 the Policy Institute at King's College London brought a group of these stakeholders together in an innovative and interactive 'policy lab' to consider what approaches the review could take to six 'areas of tension' that had been identified as being of potential relevance to the review:

1. The increasing overall rates of detention.
2. The higher rates of detention amongst Black and Minority Ethnic (BME) groups.
3. The use of Community Treatment Orders (CTOs).
4. The interface between the use of the MHA and the Mental Capacity Act (MCA).
5. The current and potential use of so-called 'advance directives'.
6. The approach to 'positive rights' and their potential inclusion in mental health legislation.

What is a policy lab?

One of the ways in which the gap between evidence and policymaking can be narrowed is through policy labs. Policy labs are collaborative sessions that bring together research, policy, practitioner and service user expertise to assess the evidence, understand barriers and constraints to change and use this understanding to inform policy options that can help improve outcomes. All policy labs seek to draw out a wide range of perspectives and views to ensure that options and ideas are challenged and deliberated. Policy labs focus on a particular issue or challenge. Previous policy labs undertaken by The Policy Institute have focused on issues such as reducing the costs associated with rising levels of type 2 diabetes and improving access to and use of effective land de-mining techniques.

The discussions drew on the latest data and evidence combined with an assessment of the overall direction the mental health system might take into the future. From this, a number of principles and proposals emerged for the review to consider.

Four principles to shape the future of the MHA

1. Protections and prevention should be balanced with a more person-centred approach.
2. The concept of risk should take more account of risks the individual prioritises and avoid the 'slippery slope' towards a wider set of risks prioritised by the state.
3. The MHA should evolve towards a framework that places greater emphasis on the ability of people to make their own decisions about care and treatment.
4. To minimise detentions, alternative approaches are needed.

Proposals for the six 'areas of tension'

1. Undertake additional analysis to understand what is driving the increase in detention rates.
2. Tackle BME overrepresentation by building a 'culturally competent service' based on understanding the reasons for variations in how BME individuals are assessed and treated.
3. Abolish, or phase out, CTOs.
4. Incorporate some form of decision-making capacity (DMC) test into the MHA, perhaps along the lines of the SIDMA approach used in Scotland, and work with the Law Commission recommendations to further simplify the MHA-MCA interface.
5. Encourage the increased use of advance care planning and undertake additional analysis of advance decision-making in mental health compared to physical health.
6. Enshrine positive (or 'social') rights in legislation as a counter-balance to the risk-based orientation of the Mental Health Act and the individual liberty orientation of the Mental Capacity Act

Implications for the broader policy context

- The MHA is one of several pieces of legislation that inter-relate and impact on each other and it will be a challenge to review the MHA in isolation from these.
- While some of the problems around the MHA relate to the law and its application, most of the challenges to be resolved flow from issues around available resources and ways of working within the mental health system.
- There are values to be balanced in reform of the MHA. These include: a) valuing the individual vs valuing the public, and b) valuing legal safeguards vs valuing informal health and social care arrangements. These balances are political (though not party political) and greater efforts should be made to generate a consensus on them.

Four proposed principles to shape the future of the MHA

1. Protections and prevention should be balanced with a more person-centred approach.

In line with developments in international human rights, the MHA should give more prominence to the rights of the individual and their autonomy in decision-making. The language should focus on health, recovery and social connections, with more emphasis given to investing in non-compulsory options and a more person-centred approach to people for whom compulsory options can protect them from harms. There will always be a very small number of people whose mental health will predominantly pose a risk to third parties but the real scale and predictability of this threat should be communicated to politicians and the public to avoid a counterproductive approach by the state.

2. The concept of risk should take more account of the risks that individuals prioritise and avoid the 'slippery slope' towards a wider set of risks prioritised by the state.

The participants were keen for protection where it is proportionate to the nature of risk. Most stakeholders in the UK, not just the public and politicians but also carers, patients and professionals, agree with provision of compulsory treatment where sufficient risk can be demonstrated and people will become more unwell without treatment (as evidenced by surveys and feedback from charities and professional bodies). However, it is important to scrutinise how the balance of risk is being enacted through the law. So, for example, potential risks that service users prioritise concerning any detention or delay on detention should be given weight. For detention this could include the loss of personal liberty, loss of dignity, impact on jobs, separation from family/other relationships and violence from other patients. For delay on detention this could include deterioration of health, loss of dignity, impact on jobs or finances and aggressive or suicidal actions. Participants thought the MHA needs rebalancing

to avoid the 'slippery slope' of prioritising state-focused risks over those of concern to the individual, especially as the definition of what constitutes mental disability or disorder has been gradually broadening.

3. The MHA should evolve towards a framework that places greater emphasis on the ability of people to make their own decisions about care and treatment.

Application of the MHA is currently grounded on the assessment of a 'mental disorder of a nature and degree'. Shifting this to assessment of decision-making capacity would underscore the importance of respecting individual decision-making and have the goal of achieving greater parity with decision-making about physical health, which is based on an assessment of what a person can do rather than on what condition, or status, they have. Many participants thought assessment of DMC was subjective but there was widespread agreement that this area is evolving and that processes exist which could increase objectivity (see box, p. 6). There was also widespread support for the Scottish test of Significantly Impaired Decision-Making Ability (SIDMA) used with a mental health decision-making specificity rather than as a global test.

4. To minimise detentions, alternative approaches are needed.

Reducing the number of detentions requires wider policy commitment to make alternatives to detention real. This includes improved: access to housing; community mental health support across the lifespan, at different phases of illness; opportunities for informal inpatient treatment; integration between health and social care to prevent services operating in siloes. Providing decent services of this kind and ensuring that they are accessible to all should be fundamental to a mental health act of the future that engages with positive rights.

Proposals for the six ‘areas of tension’

1. It is not clear what is driving the increase in detention rates and the MHA review should call for more analysis on this.

It is well known that rates of detention under the MHA have been steadily rising over the last ten years (see Figure 1). However, it is possible that this results not from the nature or application of law itself but is instead driven by other factors, such as real increases in the underlying level of need and change in associated areas of law, e.g. the change to the definition of ‘deprivation of liberty’ by the UK Supreme Court.

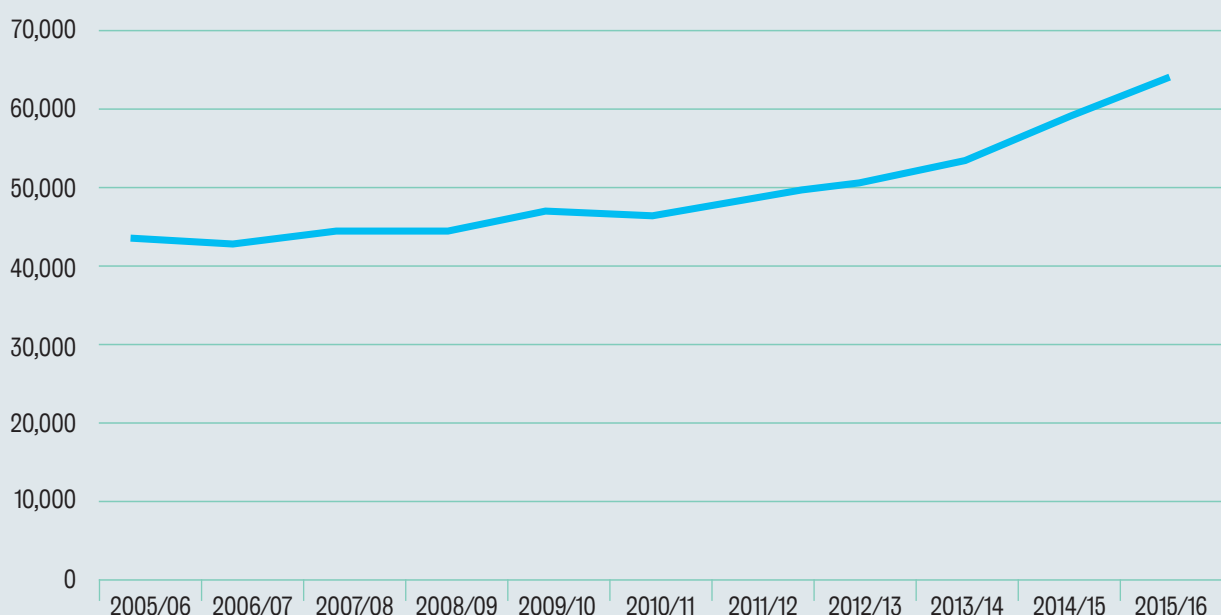
While there is a reasonable amount of data available on the rates of detention not enough analysis has been done to tease out the causes. The MHA review should call for further work to be done to understand better the reasons for the increase: is there a genuine growth in the underlying need and/or is the MHA being used in ways for which it was not intended? Is the increased number of detentions because of changed definitions of who needs legal safeguarding?

Are more people being detained or the same people more often, or both? Is the reduction in community-based treatment and care services a contributing factor? Are more MHA assessments being referred from the well-known ‘shadow mental health system,’ the criminal justice system?

2. Tackling BME overrepresentation requires a ‘culturally competent service’ and an understanding of variations in how BME individuals are assessed and treated

The increased detention rate for BME individuals was thought to be linked to more complex illness courses, higher levels of contact with the police and being statistically more likely to be assessed. Furthermore, evidence points to the incidence of major mental disorders being significantly higher among some BME groups in the UK. It was felt important though not to view the BME population as ‘monolithic’. More work is needed to understand its diversity and the different cultural narratives that play a part in leading to the need for care and then the way that care is accessed and received.

Figure 1: Total number of detentions (2005/06 – 2015/16)



Source: KP90, NHS Digital

It is not obvious that there is anything that can be done via statute to reduce the rates of detention amongst BME individuals, but lots of (potentially politically challenging) questions can be asked by the review. Research into the impact of the economic and policy context (for example, the defunding of housing, reductions to social care and changes to NHS community support) would provide essential contextual data. More work also needs to be done to ensure that we have a 'culturally competent service' which can serve communities effectively and act without bias.

3. Participants at the Policy Lab strongly supported the abolition, or phasing out, of CTOs

There are currently around 6,000 people on CTOs, of whom a much smaller number are on CTOs in contexts linked to criminal justice. For civil settings, there are other legal and service provisions that could be used to provide community mental health care and ensure mental health act assessment in the event of concern. CTOs have remained highly controversial in England and Wales since their introduction and there is accumulating evidence for them not being effective.

The abolition, or phasing out, of CTOs was seen by the policy lab participants as a priority and would speak to one of the important concerns in the BME and human rights community.

In doing so, it will be important to develop a smooth, effective and safe process for transitioning to a 'post-CTO' world, which may require special attention to the use of CTOs in a criminal justice context.

4. Most participants favoured the incorporation of some form of decision-making capacity test into the MHA, perhaps along the lines of the Scottish SIDMA approach. There was also encouragement for the MHA review to work with the recent Law Commission recommendations to further simplify the MHA-MCA interface.

In line with the view that there is a long-term shift towards increasing respect for individual autonomy there was cautious support for a DMC criterion to be included within the MHA. It was suggested that the model of Significantly Impaired Decision-

Making Ability (SIDMA) as used in Scotland could provide the model for a test around core aspects of mental health care, as long as this has 'decision specificity' (i.e. those decisions relevant to the treatment of the patient) rather than being used as a 'global assessment'.

The potential challenge to this is whether there can ever be an objective assessment of DMC. Participants recognised that there was the need for a more nuanced consideration of what constitutes loss of DMC and to determine if the DMC test is sufficiently objective to be used in overturning basic human rights. A second policy lab aimed to explore some of these issues in depth and its findings are briefly summarised in the box on page 6.

DMC is fundamental to the Mental Capacity Act (MCA) and the Law Commission has made recommendations concerning the complex MCA-MHA interface. There was encouragement for the MHA review to build on the 'Liberty Protection Safeguards' scheme proposed by the Law Commission with a view to further simplifying the MHA-MCA interface.

5. There was agreement that the MHA should encourage the increased use of advance care planning and undertake additional analysis of advance decision-making in mental health compared to physical health.

There are a number of types of advance care plans (ACPs) that could play a helpful role in ensuring that a patient's wishes are respected. ACPs can act as a mechanism for ensuring that those surrounding a patient are more attuned to spotting signs of deterioration and have guidance on how to act. In doing so they ensure that the service user's voice is heard more effectively.

An effective increase in the use of ACPs would most likely need the MHA to incorporate decision-making capacity assessment, as discussed above and balance binding with non-binding elements. Participants were in agreement that the MHA should seek to achieve this and that further work should be undertaken to clarify similarities and differences between advance decision-making in physical and mental health.

6. A majority of participants sought a future in which positive rights in legislation serve to augment the risk-based orientation of the MHA and the individual liberty orientation of the MCA.

Reflecting on the general tendency to think of mental health law within a restricted framework of civil and political rights such as right to liberty or right to life, there was interest in broadening

the framework to consider more positive rights (sometimes called social rights), including the right to have good healthcare provided and for it to be accessible, the right to get suitable care and treatment in return for detention, the right to decent housing, etc. There was considerable interest in these positive rights being built into a future mental health act that truly enacts a ‘health’ title and aspiration.

How should we assess decision-making capacity?

A second policy lab, convened in February 2018, focused specifically on evidence and objectivity in the assessment of decision-making capacity (DMC). It was attended by a diverse group of clinicians, legal practitioners, service user representatives, charities and researchers.

The majority of participants agreed that some form of DMC assessment should be used to help balance protection with a respect for autonomy and an individual’s decision-making rights. However, while it was agreed that an assessment of DMC should act as *one* determinant of rights, participants cautioned that it should not be the *sole* determinant. From the perspectives of clinical staff, politicians and the public there is still a need to consider risk, and there was a notable conservatism among some service user representatives to maintain a framework that protects the individual from harm (as noted in the first policy lab).

It was recognised that achieving complete objectivity in assessing DMC is unlikely to be possible, given the variety of definitions, derived meanings and uses of the term ‘objective’, as well as the unavoidable social constructs and pressures which surround it. Neither should striving for complete scientific objectivity be seen as the ultimate goal, as it was acknowledged that this is an area where the exercise of judgement is both needed and desirable.

But it was also generally agreed that there are other standards of objectivity that are relevant in this area, and should guide and constrain practices of DMC assessment. Participants were in broad agreement about both factors which compromise objectivity and factors which support it for this area of law and practice. Some of the positive ideals participants identified were:

- The outcome should not be driven by who pays
- The test should not be driven by best interests or by a protection imperative
- The environment of testing should not introduce pressures or biases
- The option framing should not be biased
- Clear and transparent reasoning should be shown
- There should be an ability to challenge and appeal the outcome (and not simply by seeking a second opinion from a similar expert)

Guidance and training for DMC assessment was also considered important to:

- Recognise that assessment can be coloured by the values, ideas and viewpoints of clinicians, judges and those providing treatment and care
- Develop skills at seeking and using evidence, especially in hard cases

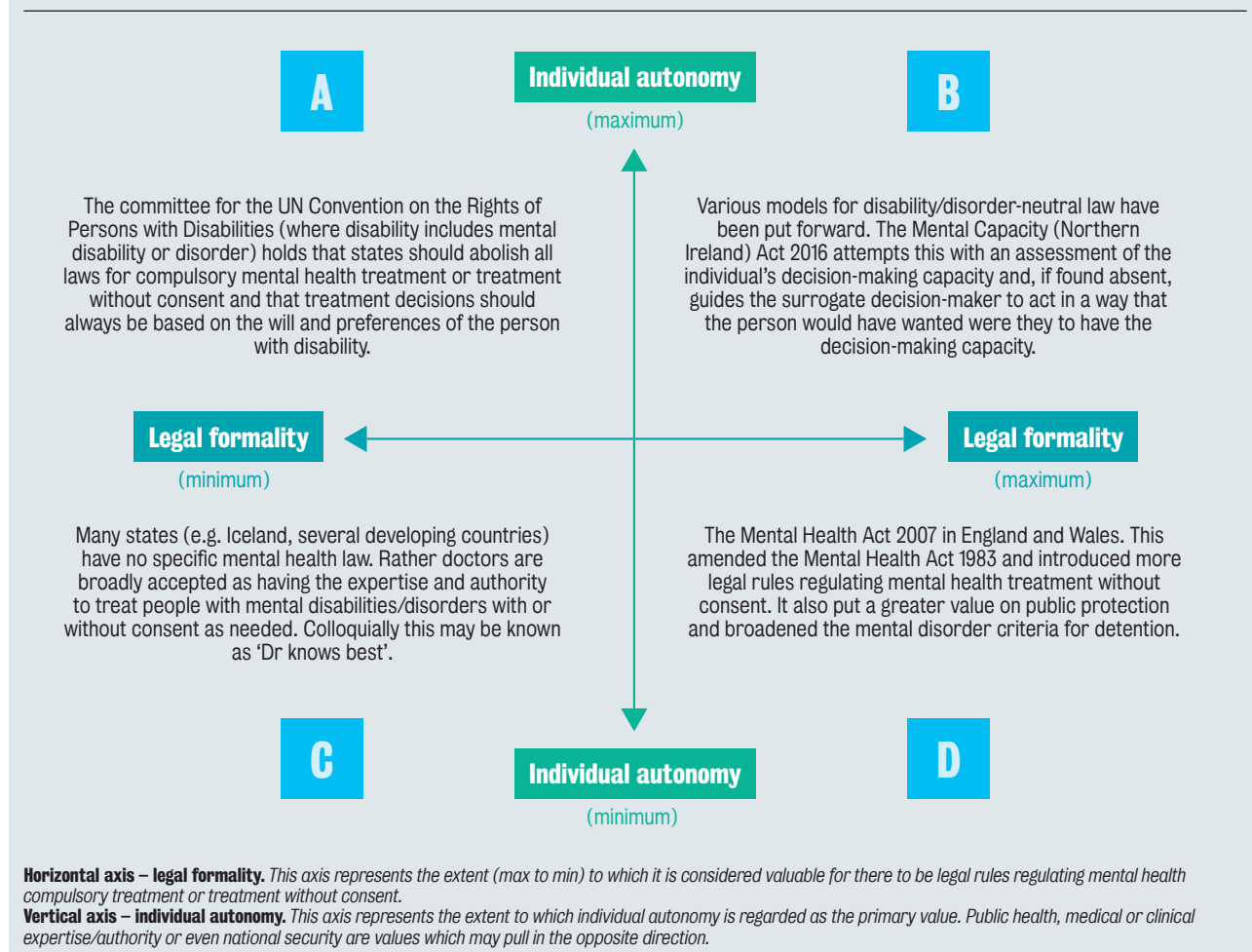
Finally, it was noted that such a system needs to be appropriately resourced, both in absolute terms so that thorough assessments can be conducted by well-trained professionals, and in ensuring that resources are distributed to minimise regional variation in provision.

Implications for the broader policy context

There are a number of overarching policy considerations, which should be borne in mind as the backdrop to the MHA review. These include:

- The MHA is one of several pieces of legislation that inter-relate and impact on each other and it will be a challenge to review the MHA in isolation from these.
- While some of the problems around the MHA relate to the law and its application, most of the challenges to be resolved flow from issues around available resources and ways of working within the mental health system (for example, the number of beds and the fragmentation/variation of services on the ground) as well as lack of knowledge about mental disability and disorder.
- The reform of mental health law must be informed by and reflect a number of sometimes competing values. The decision on what weight to give each of these values and where to place the balance point was widely regarded by participants as largely political in nature (though not party political). In striking this balance, the aim should be to gain consensual agreement at the macro level, in order to minimise political intervention at the micro level. In the policy labs we represented the decision space in terms of two orthogonal axes giving prototypical positions in the four quadrants of the grid (see Figure 2). Across the two policy labs, there was a broad but not universal consensus that the balance point in future should ideally move from quadrant D towards quadrant B.

Figure 2: Striking the balance between legal formality and individual autonomy



Taking these ideas forward

The complexity of the policy-making context discussed at the start of this paper may mean that it is neither desirable nor feasible to take forward in the short-term all the ideas presented here. Of the practical proposals around the six ‘areas of tension’, the highest priorities for immediate consideration are likely to be understanding better the causes of increased detentions (including the higher rates of detention amongst BME groups), phasing out CTOs and making sure that the MHA/MCA interface works as effectively as possible in the interests of patients.

Beyond that, the pace at which change can be effected over time is hard to predict. Nonetheless, it would be expected that a shift towards legislation that takes a DMC-led approach, enshrines positive rights and enables individuals to take greater control of the advanced planning for their care, is an achievable aspiration in the not-too-distant future.

At the very least, effort will be needed to communicate changes in a way that effectively influences politicians and the public, including thinking about the moral significance of the legislation for England and Wales, and how every extended family in the land is touched by its effects.

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