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Reforming the Mental Health Act - Approaches to Improve Patient Choice

Overview

- The Mental Health Act 1983 has been criticised as being overly restrictive, with inadequate scope for patient choice and autonomy.
- The Government's Draft Mental Health Bill proposes reforms to improve patient choice. A joint parliamentary committee report on the draft Bill recommended further changes to enhance choice, including a statutory duty to offer patients advance choice documents. Reports to date suggest that advance care planning could offer some benefits, but uptake can be low.
- Proposals to replace the Nearest Relative who has certain powers under the Act, with a Nominated Person of the patient's choosing, have been widely welcomed. There are questions about operationalisation and safeguarding.
- Alongside the reforms, the Government is piloting 'culturally appropriate advocacy', which preliminary findings suggest could help advocates better support patients from ethnic minority backgrounds.
- The draft Bill removes learning disabilities and autism as grounds for detention under Section 3 of the Act. Stakeholders have raised concerns about unintended diversion to more restrictive pathways, such as the criminal justice system.
- A range of stakeholders share the view that careful implementation is needed to maximise the benefits of proposed reforms.
- The Government has not announced when the Bill will be introduced.

Background to reforming legislation

The Mental Health Act (1983)

The Mental Health Act 1983 (MHA) sets out criteria for detaining and compulsorily treating patients* with a mental disorder in hospital without their consent in England and Wales.[1] This disorder may place that individual or others at risk, because for example they may not recognise that they are ill[2], and require urgent treatment.[3]

The MHA allows for people with a mental disorder to be detained against their will ("sectioning") in hospital,[4] usually a psychiatric unit, for assessment and/or treatment[5] for varying time periods.†

The MHA was amended in 2007 to change, among other things, the scope of what constitutes a mental illness and introduced Community Treatment Orders (CTO).‡ [6]

In response to concerns including the rising rates of detention under the Act and its disproportionate use against people from ethnic minority backgrounds,[7,8] the Government commissioned an Independent Review,§ which reported in 2018.[9]

Most recommendations were adopted in the Government's 2021 white paper, Reforming the Mental Health Act.[10] In 2022 the Government published a Draft Mental Health Bill to modernise the legislation.[11]

Parliament convened the Joint Committee on the Draft Mental Health Bill in 2022 to scrutinise the draft Bill.[12]

The Commons Library briefing, Reforming the Mental Health Act[13], gives further information on the white paper,[14] the draft Bill[15] and the Joint Committee's report.[10] This POSTnote focuses on choice and autonomy.**

Interaction of the Mental Health Act (1983) with other legislation – the Mental Capacity Act (2005)

The Mental Capacity Act 2005 (MCA) provides a broader framework for decision-making where a person temporarily or permanently cannot make their own decisions.[18] The proposed reforms have implications for the interface between the two Acts relating to patient choice. Although the MHA is not capacity-based, patients

* The term patient is used throughout this POSTnote; other terms may be used by stakeholders, such as service user or client.

† Section 2 allows for admission for assessment only, up to a maximum of 28 days. Section 3 allows for admission for assessment and treatment for up to six months and can be subsequently renewed.

‡ Community Treatment Orders extend the restrictive powers of the Act outside hospitals.

§ The Independent Review's recommendations centred on four principles: choice and autonomy; least restriction; therapeutic benefit; and the person as an individual.

** This complements other POSTnotes focussed on Mental Health Act reforms, including on Race and Ethnic Inequalities (POSTnote 671)[16] and Children and Young People (POSTnote 685).[17]

may lose the capacity[19] (Box 1) to decide whether they require admission to hospital and may refuse treatment as a consequence of a mental disorder.* However, patients retaining capacity regarding admission who do not consent to admission may still be detained under the MHA.

Box 1: Mental capacity

Mental capacity is the ability to make independent decisions. It is decision specific; for example, a patient may have capacity to decide about treatment for a physical health condition, but not if they need admission to hospital for a mental disorder.[20] It requires understanding and retaining the information relevant to the decision, using or weighing it up, and communicating a decision. Capacity can change over time for each decision, as it may be affected by the course of an illness.†[21]

While many psychiatric inpatients have the capacity to make treatment decisions, incapacity is common when unwell and detained in hospital; around 29% in a review of studies,[22] although estimates vary widely.[23–25]

Patient choice and the MHA reforms

Many stakeholders, including mental health charities, view the MHA as overly cautious and risk-management focused.[26,27] The reforms seek to shift to a more patient-centred framework.

Stakeholders state that reform will enable wider cultural change, whereby mental health services and relevant agencies prioritise individual autonomy and minimise restrictive practice, while maintaining patient and public safety.[28]

The draft Bill aims to reduce detentions and give detained patients greater choice in care decisions.[12] The Joint Committee noted that enhancing choice could help to reduce detentions and narrow health inequalities.[14]

Research has identified that increasing detention rates are partly attributable to fewer informal admissions.‡ This may be due to greater recognition that patients who lack the capacity to consent to the confinement that inevitably accompanies admission,

* Patients may also refuse admission to hospital for reasons other than the effect of their mental disorder, for example because they have had a bad experience during a previous admission.

† Capacity may come and go in a relapsing and remitting illness, such as bipolar affective disorder. Capacity may become permanently lost in a progressive condition, such as dementia. Capacity may never be present in neurodevelopmental conditions, such as a learning disability.

‡ An informal admission is where a patient is admitted voluntarily to hospital for treatment of a mental disorder.

but are not actively objecting to admission, should still be assessed for detention under the MHA.* [29–31]

The National Institute for Health and Care Research invited researchers to bid for funding to evaluate aspects of the proposed reforms, including:

- changes to detention criteria;
- introduction of Nominated Persons;
- automatic referral to an advocate;
- evaluating culturally appropriate advocacy pilots.[32]

NHS England is leading a quality improvement programme based on principles including optimising choice and autonomy. Through local innovation and sharing best practice, it will develop practical solutions that can be implemented without legislative change.[33]

Care and Treatment Plans

The draft Bill proposes statutory CTPs (Box 2) for detained patients,† [15] widely supported in the white paper consultation. As proposed, they would guide current and future treatment.[15,35] Clinicians would be required to prepare these with patients wherever feasible, and to review and update them regularly as needed.

The Joint Committee noted the proposals were widely welcomed, but patients have raised concerns CTPs could become box-ticking exercises without obligations to act on recommendations.[14]

* A patient may require hospitalisation due to deterioration of their mental disorder. They may lack the capacity to decide whether they should be admitted, for example because they do not recognise that they are unwell. However, if offered a voluntary (informal) admission, they may passively comply. Under these circumstances they should undergo a formal Mental Health Act assessment and be detained if the criteria for detention are met.

† Statutory CTPs were introduced in Wales in 2012 but their design and purpose differs to the proposed changes in England.[34] They were introduced through the Mental Health (Wales) Measure 2010.

Box 2: Glossary of terms used in this briefing

Care and Treatment Plans (CTP) consider how patients' needs arising from their mental disorder will be met and should be developed with patients.

Advance Choice Documents (ACD) are prepared by individuals when they have decision-making capacity, to specify future mental health treatment preferences when unwell, such as choice of medication, and care more broadly.* [36]

Advance Decision to Refuse Treatment (ADRT) is a legally binding document under the provisions of the MCA setting out a patient's decision to refuse certain treatments if they lose capacity.[37] ADRTs do not request treatments or express preferences around wider care.[38] They apply only to adults.

Lasting Power of Attorney (LPA) enables individuals over 18 with capacity to designate someone under the MCA to have decision-making powers (for health and welfare, and/or property and financial affairs) on their behalf when capacity is lost.[39]

Nominated Person (NP) would be chosen by a patient and has certain rights under the MHA.† These powers are distinct from the LPA and these roles could be held by different individuals.

Independent Mental Health Advocates (IMHA) inform patients of, and help them exercise their rights under the MHA.[40]

Mental Health Act Tribunals are independent expert panels that review patients' detention under the MHA.[41]

Advance decision-making in healthcare

Healthcare processes giving people the opportunity to specify their wishes in a range of future scenarios are used in various contexts.[42] Documents concerning advanced decisions take different forms, with varying degrees of enforceability; some are legally binding while others are advisory.

The MCA contains provisions for people to specify legally binding ADRTs and identify individuals who can make decisions on their behalf under an LPA (Box 2).

The draft Bill takes the same approach as is taken under the MCA when decisions are being made on behalf of a person who cannot currently make their own decisions.[15]

* For example, a patient who becomes agitated may have a preference regarding the approach staff use to help them calm down.

† In the proposed reforms the NP would replace the Nearest Relative, who is chosen automatically by an approved mental health professional (AMHP) from a fixed list.

The draft Bill also provides a framework within which advance refusals by patients are to be treated as equivalent to contemporaneous refusals. Whilst refusals would not be binding, the threshold for overriding them is set high.[15]

Advance Choice Documents (ACD) are not currently provided for expressly under the MHA, but the Code of Practice to the MHA makes clear that wishes and feelings expressed by patients in advance should be considered seriously by clinicians.[43]

The Independent Review recommended a statutory duty on clinicians to offer ACDs to allow previously detained patients to express preferences about their care and treatment, including during any future detention.[9] White paper consultees were supportive of the proposed scope of ACDs, but cautioned against limiting their content and emphasised effective implementation.[44]

The draft Bill stated that clinicians should 'consider a patient's past and present wishes, feelings and beliefs and values' for patients lacking capacity, but is not prescriptive about how, other than to consult relevant people.[15]

The Joint Committee recommended that the Government consider the inclusion of the right to make an ACD within primary legislation for all detained patients.[45]

Evaluating the impact of ACDs in mental health care

Documents similar to ACDs in mental health care have existed in various forms for some years, both in the UK and elsewhere.[42] Research shows that patients welcome ACDs and value them in practice. Uptake can be low, although this may be due to lack of support to complete them.[46–48]

ACDs are difficult to research, as it can be challenging to measure outcomes and isolate contributory factors in such a complex intervention.[49]

Research to determine if ACDs are effective at improving outcomes has given mixed results, but suggest that overall they can reduce detentions and may have a particularly beneficial impact for Black patients.[50,51]

Stakeholders note that while reducing detentions is desirable, some are unavoidable.[9,10]

Pilots are underway in England to explore how ACDs can be effectively implemented, considering aspects including consistent documentation, digital access and fostering trust, particularly in ethnic minority communities.[52]

Attitudes to ACDs and scale of use

Surveys demonstrate advance decision making in mental health conditions is mainly supported by patients and clinicians.[53–55] Despite this, uptake has often been low. In Australia, under 3% of patients have made advance statements under the Victorian Mental Health Act 2014, despite initiatives to encourage this.[56]

Advance statements are available in Scotland, since the implementation of the Mental Health Act (Scotland) 2003.[57] However, uptake is at 6.6% for those with significantly impaired decision-making ability detained under the Act.[58] The most comprehensive review to date in 2009[59] attributed low uptake to:

- most people not knowing about advance statements;

- not knowing how to make one;
- trusting providers to select appropriate treatments;
- finding it hard to contemplate being unwell and a fear that wishes may be overridden. Data at the time suggested this was rare, but 2021 data showed that 36.9% of advance statements were overridden.[60]

Self-binding directives

A controversial type of advance decision known as a self-binding directive (SBD) can be created by a patient when well, to request future involuntary treatment even if they anticipate that at the time the treatment is required they are likely to refuse it.[61] They are either legally binding or advisory.

SBDs are promoted in some countries as a means of increasing the autonomy of patients with severe, episodic mental illnesses.[*] [†] They may encourage clinicians to act at an earlier stage of a relapse when treatment may be more effective. In a UK survey including 565 participants with bipolar disorder, 82% supported SBDs.[63]

Critics highlight that SBDs may reduce rather than enhance autonomy and there is no right to demand a particular treatment. They caution that SBDs may create unrealistic patient expectations, or could mean that those with an SBD are inappropriately prioritised for limited inpatient beds.[64]

Recent research examining the effectiveness of ACDs

Research suggests that patient satisfaction and treatment adherence would improve by involving patients in decisions.[65] Interventions such as ACDs that involve patients in expressing preferences may also reduce compulsory admissions.[50,51]

Research summarising the effects across several studies of crisis-planning interventions, including ACDs, for patients with severe mental illness showed a 25% reduction in compulsory admissions for those holding an ACD, but insufficient evidence of reduced length of stay or admissions overall.[51] Similar research reviewing multiple studies focusing on community mental health patients found a 23% reduction in compulsory admissions where ACDs were used.[50] This has been attributed to patients being admitted earlier on a voluntary basis.

Appropriate voluntary admission is ethically preferable, can be cheaper, and may be associated with better outcomes such as improved medication adherence and greater trust in services.[66,67]

The CRisis plan IMpact: Subjective and Objective coercion and eNgagement (CRIMSON) study is the largest clinical trial of ACDs (Box 3).

Part of the Government's economic impact assessment of the MHA reforms is based on an estimated reduction in detentions through ACDs of 7%, 25% and 39% in the low, central and high benefit scenarios respectively. This corresponds to anticipated savings over 10 years of £94 - £524 million (central estimate of £336 million).[68] These

[*] An example of an illness with this characteristic is bipolar affective disorder.

[†] SBDs have been legally binding in The Netherlands since 2008, although uptake is low. Data shows that 0.32% of court-authorised involuntary treatment involved a self-binding directive.[62]

would only be achieved with a relatively high uptake and where this translates to reduced detentions.

Box 3: The CRIMSON Study

A total of 569 participants from 64 community mental health teams in England received either the Joint Crisis Plan (JCP) (an ACD created with patients, outlining future treatment preferences) or treatment as usual. JCPs were not shown to be effective in preventing detentions, but patients reported improved therapeutic relationships with clinicians. There was evidence that the JCPs were not fully implemented at all study sites.[69] An economic evaluation suggested a higher probability (80%) of JCPs being the most cost-effective option, with this probability rising to 90% in the Black ethnic group.[70] A previous, smaller trial did show a significant reduction in compulsory admission in the intervention group.[71]

Refining the design of ACDs to improve their effectiveness

While the National Institute for Health and Care Excellence has not recommended any particular ACD model, research is underway to develop new approaches.

In recognition of the complexities of implementation, researchers at King's College London have developed a prototype ACD.[72] The template and guidance was co-designed with over 90 stakeholders, including patients, carers, legal experts, service user-led organisations and clinicians.[73] A co-produced template called a 'Crisis PACk' and process for completing the document were subsequently piloted and refined.[52]

The results highlight that active support is necessary to help patients engage with the process. Systems are needed to support awareness of and access to completed ACDs between agencies, such as NHS Trusts, the police and ambulance service. This would require robust digital systems to share data and documentation.

An academic critic has questioned whether better documentation alone is sufficient to remove the barriers to effective implementation of advanced decision making.[74]

Teams at King's College London are developing a package of measures designed to build trust in Black communities through ACDs and other mechanisms.*[75] NHS Trusts such as South London and Maudsley, in collaboration with universities, are working on ways to implement ACDs, including digitisation to make them available when required.[76,77]

Nominated Person

Under the MHA the 'Nearest Relative' (NR) has certain rights and responsibilities if a person is detained under certain sections or is on a CTO.[78] The NR must be over 18, and among other things, can apply for or object to that person being detained or placed under guardianship.[79] The NR can also apply to discharge someone and

* Results from research have been published but have not yet been peer reviewed.

appeal to a Mental Health Tribunal if their application is barred by the patient's responsible clinician.[80] Some report difficulties managing these responsibilities.[81]

The NR is selected automatically by the AMHP from a hierarchical list, based on their familial relationship to the patient. This is widely criticised as undermining patient autonomy and failing to reflect changing family structures and relationships.[82]

Proposed changes

The draft Bill proposes replacing the NR with an individual of the patient's choosing.* [15] The NP would have extended rights, including:

- a right to be consulted
    - on the statutory CTP;
    - about transfers between hospitals, and renewals and extensions to the patient's detention or CTO;
- the power to object to the use of a CTO and apply for discharge on the patient's behalf.

The NP would be provided with additional support given the expansion in role and powers. A patient with capacity/competence could select a NP, before, during or after assessment or detention.

White paper respondents said that NPs could provide better safeguards than NRs, as family relationships may be complex and may raise safeguarding risks. They also highlight that someone chosen by the patient may have better knowledge and understanding of the person, their illness, social situation and preferences.[82]

The proposed NP has similarities to the 'named person' in the Mental Health (Care & Treatment) (Scotland) Act 2003,[57] where uptake has been low. Between 2018 and 2020 around 25% of those detained identified a named person, falling to 11% for people under short-term detention orders.[83] Scotland has created provision for a 'listed initiator' in lieu of a named person when nobody is chosen.[84]

The white paper included proposals for an Interim Nominated Person to be appointed by an Approved Mental Health Professional (AMHP).[82] Under the draft Bill, if someone lacks the relevant capacity to make a nomination, and has not previously nominated anyone, an AMHP can appoint a NP on their behalf until the individual regains capacity.[15]

The Joint Committee heard that current proposals are operationally unworkable and recommended that Government review the proposals with AMHPs to address these practical concerns. [14] It also supported the inclusion of NP in ACDs, which patients should have a statutory right to request.

* This NP must be over 16 (or over 18 if the patient is under 16).

The British Association of Social Workers supported the proposed changes, but has raised questions about other aspects of implementation, such as what happens when a NP is inappropriate or unsuitable.[85]

Approaches to improve advocacy

Patients can appoint an Independent Mental Health Advocate (IMHA) to support them in understanding and exercising their rights, such as applying for a Mental Health Tribunal review.[40] This role is distinct from that of the NP, as IMHAs have specific training to perform their role and do not share an NP's powers.

IMHAs are independent of mental health services, but some have raised concerns about their status in situations where advocacy services are commissioned by providers.[86] Healthcare staff have a duty to inform detained patients about advocacy. However, stakeholders have criticised this as insufficient, and a reason why too few eligible patients receive advocate support.[87]

The white paper outlined expanding the advocate's role to enhance access to services and the support offered, proposing that IMHAs should be able to apply to the Mental Health Tribunal on the patient's behalf. Stakeholders also support the draft Bill's proposed extension of the statutory IMHA right to all mental health inpatients, including those not detained under the MHA.[*86]

The draft Bill's proposal that detained patients are offered "opt-out" advocacy is welcomed, and the Joint Committee recommended this should be extended to informal patients when capacity allows.[14] The Committee also recommended the creation of a Mental Health Commissioner to enhance patient choice and autonomy.[†]

Culturally appropriate advocacy

Cultural appropriateness could relate to various characteristics, such as sex or sexual orientation, but here focuses on race. This is in response to disproportionate rates of detention in people from ethnic minority backgrounds and concerns that advocacy may not be well suited to these communities.[86]

Identified barriers to accessing mainstream advocacy services include:

- lack of provision of appropriate advocates;
- mistrust of mental health services;
- failure to account for ethnic identity and linguistic diversity.[91,92]

[*] Wales has this provision.

[†] The Joint Committee recommended that a Mental Health Commissioner could advocate for patients' interests,[14] akin to other commissioner roles.[88,89] The effective handling of complaints when rights are not respected could provide another mechanism to enhance patient choice and autonomy.[90]

Culturally appropriate advocacy has been defined by a Government commissioned scoping report as "a service that is able to understand and respond to the varied and individual needs of BAME people".[93] This also notes that most participants emphasised the need for access to an ethnically representative workforce.

Significant dimensions of culturally appropriate advocacy include:

- the advocate's ethnicity;
- time to build relationships and establish trust;
- the benefit of attitudinal changes; and,
- addressing gaps in rights-based knowledge.

The Government aims to support access to culturally appropriate advocates for all detained patients and is funding research and pilots.*

The Joint Committee noted shortages of advocates with specialised knowledge of learning disabilities and autism. It recommended a 'Central Advocacy Service' to meet the needs of specific groups including people with learning disabilities and autistic people, and children and young people.[14]

The resource implications of implementing the proposals in full were highlighted and the need for adequate recruitment, training and resourcing of an expanded advocacy workforce.[14]

Tribunal review

Mental health tribunals are panels† that independently review a detention under most sections of the MHA.[94] Patients or their nearest relative can apply for a tribunal review, or they may be triggered automatically. Tribunals may have the power to discharge patients who do not meet the criteria for ongoing detention.‡

The draft Bill proposes that detained patients under section 3 have more opportunities to appeal in the first year, and those under section 2 can apply for a tribunal up to 21 days after their detention starts, rather than the current 14.[15]

The draft Bill did not include the Independent Review's recommendation that treatment decisions can be referred to a separate tribunal. The Government stated that this was in response to concerns raised about the risk to patient safety of a single judge intervening in clinical decisions, which could also create conflict with the clinical team.[58] The Joint Committee recommended piloting a "slimmed down Mental

* The Government states that provision for culturally appropriate advocacy is not required in primary legislation, and that the Code of Practice may be used instead. Further work to explore this will be undertaken through local pilot projects.

† A tribunal panel is chaired by a legally qualified member and assisted by medical and specialist lay members.

‡ Tribunals do not have the power of discharge for all types of section. For example, patients detained under part III of the MHA subject to a Restriction Order will require approval from the Ministry of Justice to be discharged from hospital.

Health Tribunal" for treatment appeals in response to concerns about increased workloads from the reforms.[14]

Interaction between the MHA and the MCA

Where an adult* is deprived of their liberty, the MCA Deprivation of Liberty Safeguards (DoLS)† protect their rights in a hospital or care home.[95–97]

Where an adult lacks the capacity to consent to their confinement for purposes of providing them with care and treatment, consideration may need to be given as to whether they should be detained under the MHA or made subject to DoLS. Research has found a lack of clarity and consistency amongst decision makers in determining which Act to use.[98]

Some stakeholders advocate for fusion legislation, combining the Acts.[99] The Mental Capacity Act (Northern Ireland) 2016‡ combines decision making for mental and physical health.[100] This is modelled on the MCA and includes legally binding ADRTs and LPA with no distinction between mental and physical health.

The Independent Review and the Joint Committee discussed the potential advantages of fusion legislation, while recognising it is unfeasible in the current reforms.[9,14]

Implications for people with a learning disability and autistic people

People with a learning disability and autistic people§ [101] may have impaired capacity to make care and treatment decisions, given the nature and severity of their conditions.[102] However, decision-making abilities may be optimised with support to enhance understanding and communication.[103]

Compulsory detention of people with a learning disability and autistic people under the MHA is recognised as a human rights concern.[104] The draft Bill removes learning disabilities and autism as conditions for which people can be detained for treatment under Section 3 of the MHA.[15] These changes would not apply to Part III of the MHA, which concerns 'forensic' patients charged with or convicted of committing a crime.** [105]

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* Aged over 18 years old.

† The Deprivation of Liberty Safeguards are due to be replaced with a new system of Liberty Protection Safeguards.

‡ The legislation in Northern Ireland is not yet fully in force.

§ Learning disability and autism are lifelong conditions.

** Part III provides for longer term detention, such as under section 37, which can be used as an alternative to a prison sentence.

Stakeholders' opinions about these proposals vary. Some want learning disability and autism removed from the scope of what is considered to be a mental disorder for the purposes of the MHA.[106,107]

However, many have expressed unease about potential unintended consequences.[108] The Joint Committee noted concerns that people with a learning disability and autistic people may instead be:

- referred to the police and detained under the more restrictive Part III of the MHA or within the criminal justice system;
- diagnosed with an alternative mental health condition that does fall under the scope of Section 3; or
- inappropriately detained under the MCA, with different safeguards that some view as less stringent.[98]

These could have potentially negative implications for choice and autonomy. The removal of learning disability from comparable legislation in New Zealand in 1992[109] has been cited as a reason for people with learning disability being inappropriately diverted to the criminal justice system.[58] The Government argued that it is difficult to draw direct parallels between the changes elsewhere and current proposals.[58]

It is widely accepted that people with a learning disability and autistic people will need additional, specialised support to benefit from the proposals to enhance choice and autonomy.[14] For example, advocates will need training in overcoming potential communication barriers. A national specialist service is recommended by advocacy organisations to meet this need.[86]

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