The Challenging Behaviour Foundation
making a difference to the lives of people with severe learning disabilities

MHA White Paper Consultation – April 2021

CB-NSG Mental Health Act Consultation Meeting – Summary Paper

30/03/21

This paper summarises the discussions held during our CB-NSG Mental Health Act consultation meeting on 30th March 2021. Attendees were divided into four 'breakout rooms' to discuss specific sections of the Mental Health Act White Paper – these were Preventing Admission, New Detention Criteria, Care and Treatment, and Challenging Detention.

The notes below are an integrated summary of all of these sub-groups, as there is significant overlap in the issues discussed in each. Please note that the statements contained below are written to reflect information collected from attendees and are not necessarily reflective of the positions of the CBF.

Need for person centred planning

Professionals should work with families and support the person to be involved with planning for care themselves. Community support and services must be robust and comprehensive to meet the local populations' needs. Individual needs must be identified early (along with personal aspirations, preferences etc.) to prevent admission further down the line. There has been plenty of research on the consequences of not meeting these needs – but not on what works to help meet them. A review on what works to prevent unmet needs from leading to a crisis would be useful (but should not delay action as much is known already).

This also extends to ensuring that teams working in hospitals/inpatient units are aware of the reasonable adjustments the individual will require *if* admission is a) appropriate and b) can deliver support that cannot be delivered outside of an inpatient setting.

Commissioning

There is a lack of flexibility/responsiveness in the provision of support, which will lead to the invoking of the MHA to detain people where the support identified as needed in the community is not available. Commissioning needs to improve to prevent this – an individual's needs should be identified early on, and services commissioned (i.e. identified, developed and funded, rather than simply "buying what's available") and invested in to provided for this, rather than allowing unmet needs to escalate.

Do the proposed duties of 'adequate supply of services' go far enough to make community provision a reality? No - these duties are too loosely defined and permit too much responsibility-shifting between agencies.

The focus should be on prevention. Ideally, inpatient beds should be kept at their absolute minimum possible number to preclude the option of admission (and we definitely shouldn't be having new units being built).

Investment in robust community provision should the key priority going forward – it will prevent unnecessary admission and enable discharge. Commissioning has a key role to play here- but commissioning is an unregulated activity.

Crisis planning and 'At risk' register

Alternatives to admission need to be developed in the community – whether it is local 'crisis houses', assessment in respite facilities, intensive support or otherwise. This will address the issue of escalation of behaviours that occurs during admission following a crisis. This is needed particularly for assessments – you cannot get an accurate assessment outside of a safe environment. Assessment needs to take place in an environment as near as possible to the ordinary familiar living environment of the person.

What will ensure that this risk register captures all individuals (children as well as adults, mild/moderate/'borderline' individuals, homeless people, and individuals with complex needs) who are at risk of detention under the MHA *or* involvement with the CJS? Registration must also entitle you to immediate, well-funded specialist support targeted at preventing admission.

Assessments

Concerns over the quality of assessments – there is a high rate of co-occurrence between learning disability and autism and mental health conditions, and conversely a significant risk of diagnostic overshadowing. High quality assessment is unlikely to take place in an ATU.

Following the 28-day assessment, there are not sufficient safeguards to protect individuals who are deemed ineligible for section 3 detention – what if the bespoke package is not ready? There is a risk of discharging people to the environments which triggered their initial admission, and there is no eligibility for section 117 despite what may have been a traumatic experience. Conversely, there is a risk that following the 28-day assessment labels such as "anxiety" can be too easily applied, when the distress is caused by the environment / detention itself.

Tribunals

Tribunals do not see C(E)TRs most of the time. Courts are formulaic and reports don't mention that a C(E)TR has even taken place, and Tribunals do not look at reports on psychiatric interventions. Tribunals are risk averse, and look at whether the statutory criteria of detainment and forced treatment are being met in order to

make the detention decision, and little else. Part III conditional discharge in particular is a very complex and risk-averse process.

People sitting on Tribunals are a random selection of professionals with no requirement of specialisms (e.g. no learning disability or autism specialism).

Main barrier to moving from detention to community is the lack of available community services – it is key that challenging detention links directly to the power to ensure the development of community provision. Once detained, the outcome of a Tribunal will generally simply confirm detention – even if the person is ready for discharge.

Tribunals *may* sometimes push for discharge, but have little opportunity for pushback if told that there are no safe community options. Powers to direct services may make a difference but this needs to be made an effective check not a rubber stamp. The 5 week time-period may be helpful. But if is not met can it be extended, with accountability and rigorous scrutiny placed on the LA to resolve issues identified in previous Tribunal?

Therapeutic Benefit

How this is defined will be key to how effective it is – we can request clarity in the code of practice. If done right, this criteria can force decision makers to set out their thought process for justifying detention, which can then be challenged in Tribunal. May help to prevent overly lengthy detentions under section 3 – some concerns were had over how well this will apply to section 2.

Substantial Likelihood of Significant Harm

Attempt to raise the threshold for admission is welcome, as it will prevent the invoking of MHA in inappropriate cases (e.g. due to placement breakdown). However, the only thing that will *meaningfully* reduce admissions is adequate, appropriate and individualised community services.

Section 2 Detention Criteria

Inclusion of learning disability and autism LD&ASD as a qualifying mental disorder in part II *can be* beneficial for diagnosis by providing time and flexibility – which is often not possible in 28 days due to complexity of diagnosis in individuals with learning disabilities and autistic people. Removal may create unintended consequences by forcing discharge after 28 days, which may cause harm if need goes undiagnosed or person is discharged to unsuitable environment. There are some benefits to some people of admission (rarely beneficial for individuals with severe learning disabilities) – but are there enough safeguards to prevent this 'flexibility' from being abused?

Often individuals may not be receiving assessment by MDT while ostensibly being detained for assessment. Admission may lead to escalating behaviours and deteriorating condition, and ATU environments are not suitable. Currently, it is also

far too easy for people to find themselves on a section 3 following an admission for assessment, leading to lengthy detention.

Section 3 Detention Criteria

Does it make sense to instead simply remove *severe learning disability* entirely from the scope of the act? Such individuals will rarely if ever benefit from detention, have mental health support needs different from all others under the scope of the act, and this move would force community services to ensure provision is appropriate. Alternatively, could a *harmonized definition* of Mental Health and Learning Disability be appropriate?

Part III Detention Criteria

Not extending therapeutic benefit criteria to part III patients is discriminatory. Imposing a differential criteria as a response to a) the failures of mainstream services to make reasonable adjustments or b) the lack of trust in community sentencing options is short-term thinking, and should not come before attempts to resolve (a) and (b).

Courts can mandate NHS spending on a hospital placement, but not on treatment and support in the community under community disposals – courts will often send people to prison as they lack faith in community options.

Unintended Consequences

Removing eligibility for MHA may push people onto less protective frameworks, as well as meaning they lose out on important benefits (section 117 aftercare).

Advocacy

Advocacy as it currently exists is not working for individuals with learning disabilities and autistic people. In private hospitals, it is common for one advocate to serve the whole ward with very little meaningful involvement in any one patient. In some service providers, it is common for the advocate to be hired by the provider and report directly to them.

Advocacy (skilled and independent) should be opt-out for anyone detained under the mental health act, as well as being available for informal patients.

Advocacy should also be independent of either the clinical team or provider, and should know the person well.

Advocacy is currently fragmented and accessing advocacy needs simplifying, with families being supported to have their voices heard.

Given problems with quality, independence, availability etc, commissioning is the route to solving advocacy, not necessarily through the MHA.

Need to move away from short term issue-based advocacy to long term advocacy.

Care and Treatment

Most people should already have a community care and support plan- this needs to "go with them" and be adapted for the short-term inpatient stay. Concerns over who is involved in constructing and then implementing the plan, with too many opportunities existing to exclude families. CTPs are currently hospital-centred not person-centred, and can be completely unobtainable (e.g. "*X number of days without incident = can go outside*"). There needs to be an obligation for professionals involved in creating them to be *outward looking* and plan for beyond hospital. There should also be more scope for continuity in support – allowing 'outside' support staff to enter inpatient services, etc.

CTPs and C(E)TR needs to also include details on *why* this care/treatment needs to be delivered in a hospital, why another setting is considered not appropriate, what the person was like prior to admission, what are the other dimensions of care and support in consideration, and details on family and friends. There should be details included on the environment of care, providing a greater focus on the importance of this.

In primary care for elderly people with frequent hospital admissions there are lessons that can be learned for care planning in units – MDTs are doing real-time care planning, they are involving health and social care and carer's centre, taking on board input from carers.

Staff providing direct support are often not operating in line with CTP/C(E)TR, and do things *to* rather than with or for people. Providing support and conducting assessment requires in-depth, long-term knowledge of the person – during episodes of care in inpatient services there should be a requirement to collect information about the person. Individuals should be included in co-production regardless of whether or not they have capacity.

C(E)TRs vary in quality and lack any 'follow-through' in proposals – families are not supported to get them, there is not guarantee that the support needs outlined will ever be met, the response time (3 months) is too long,

It was criticised that decisions can be made regarding care and treatment by practitioners or staff who are neither LD&ASD specialists nor have received training. We need LD&ASD training to be included in core training for health and social care professionals.

Interface with other legislation

Of all possible reforms, fusion legislation is the most preferrable – but the government have denied the possibility of this (and the case to propose it is weakened by the fact that Wessley didn't recommend it). Alternatively, a solution proposed by the Law Commission holds that MCA/DoLS shouldn't be used to detain

people in psychiatric inpatient settings (binary solution) – making the MHA the only vehicle for such instances and avoiding the confusion over the interface.

The MCA is limited due to the conditions that have to be met before appeal to CoP, which will then have a long wait for a judgement – there should be provisions which trigger a Tribunal-like appeal whenever MCA/DoLS/LPS are used to detain someone who no longer meets conditions for detention. The Tribunal structure offers certain protections to the individual and those supporting them, while the CoP is massively overworked and negotiations can be incredibly lengthy.

Will there be any legal framework for detaining/treating those deemed ineligible for the MHA under new criteria? Do proposals leave a legal vacuum? Respite services could be used as a middle ground to discharge (step-down or locked rehab), with DoLS used in these services.

Criminal Justice System and Restricted Patients

What alternative frameworks could be useful for solving issues surrounding restricted patients? Voluntary admission to mental health wards (for those with capacity)? Patients being on remand?