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Hampshire County Council

The Mental Health Act: past, present and future

Tim Spencer-Lane, Lawyer specialising in mental capacity, mental health and social care law

The Mental Health Act: past, present and future

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agenda

- MHA case law
- Reforming the MHA
- Has the MHA had its day?

Face-to-face assessments

Devon Partnership NHS Trust v SSHSC [2021] EWHC 101 (Admin)

- Joint guidance issued by NHSE & DHSC stated that during pandemic video assessments could be used for MHA assessment by AMHPs & doctors
- The High Court however held the guidance was unlawful & it has since been amended to remove these sections
- The phrases "personally seen" in s. 11(5) and "personally examined" in s. 12(1) of MHA require physical attendance

Issues arising

- Basis of the judgment is the statutory construction of s.11(5) & 12(1) of MHA
- The judge exhorts the virtues of face-to-face assessments
- A passage suggests ‘examination’, - even without the word ‘personally’ - means face to face contact
- Can it be read across to renewals (which refers to ‘examine’)?
- Can it be read across to making & renewing CTOs (which refers to ‘examine’)?
- Can it be read across the MCA & DoLS (which does not use the word examination)?

NHS England & DHSC 'legal guidance for services supporting people of all ages during the coronavirus pandemic' (30 Nov 20)

Forced isolation

- Detained patients can be isolated under the MHA if their refusal is connected to their mental disorder
- Otherwise, MCA can be used via best interests decision used (or for children, Gillick competence or parental responsibility)
- In rare event that none of the above applies, it may be necessary to use Coronavirus Act 2020

COVID testing

- No COVID testing without valid consent
- If the patient lacks capacity, then only test if this is in the patient's best interests

Conditional discharge

SoS for Justice v MM [2018] UKSC 60

- MM had mild LD/A & pathological fire setting – convicted of arson & court made a s.37/41 order under MHA
- Applied to MH tribunal seeking conditional discharge with a proposed care package that amounted to an objective DoL
- He had capacity to consent to the care package
- Held that MHA does not permit Tribunal or Secretary of State to impose conditions amounting to DoL (even if the patient has capacity to consent to the conditions and does so)

Community Treatment Order

Welsh Ministers v PJ [2018] UKSC 66

- PJ had mild LD/A & significant behaviour disorder (which included violent and sexual offending)
- Had capacity to make decisions about his restrictions
- Discharged from hospital under a CTO with conditions that amounted to DoL
- PJ consented to the care regime
- Held - a CTO cannot authorise DoL in the community
- MHT role is to draw this to the attention of the MDT
- Ultimate remedy is habeas corpus or judicial review

Prospective discharge

MC v Cygnet Behavioural Health Ltd & SoS for Justice [2020] UKUT 230 (AAC)

- 58-year-old woman, long history of treatment resistant schizophrenia & lacked capacity on residence/care/treatment
- In 1993 placed on MHA hospital order following conviction of arson offences
- Eventually given extended leave to reside at a nursing home & care regime amounted to deprived of liberty
- Applied to tribunal for conditional discharge & solicitor invited tribunal to defer discharge until a DoLS authorisation in place
- Tribunal refused to discharge: argued it had a duty to impose conditions necessary for the patient's health/safety and protect others which cannot be delegated to an MCA decision maker

The Upper Tribunal decision

- Tribunal had misunderstood the law
- A DoLS authorisation or Court of Protection order can come into force at a future date when the patient is discharged from the MHA
- In such cases the tribunal may be able to proceed to a conditional discharge without further action
- If an advance authorisation not in place, tribunal can adjourn, make a provisional decision or defer discharge to allow the MCA authorisation to be arranged, or dual ticketed judges can be used
- If the person has the relevant capacity, the use of s.17 leave should be considered to address any deprivation of liberty

Long term section 17 leave

DB v Betsi Cadawaldr University Health Board [2021] UKUT 53 (ACC)

- Section 3 patient with bi-polar disorder
- Had been on s.17 leave for 11 months, with a 'virtual bed' at 2 different hospitals
- Whilst on leave, was living at a care home & had no contact with either hospital
- Clinical team argued that a CTO was not appropriate & he needed the discipline of being 'liable to detention'
- On this basis the mental health tribunal did not discharge

The Upper Tribunal decision

- The upper tribunal overturned this decision
- Accepted the patient might not comply with medication if not on leave, but the MHA requires that a patient must be discharged unless it is appropriate for them to be detained in hospital for treatment
- This means that the patient must be receiving a “significant component of their treatment in hospital”
- Also, the clinical team should have considered a CTO or the MCA

Issues arising

- Previous case law emphasises that treatment in hospital does not need overnight stays & in last stages the role of psychiatrist can be ‘gossamer thin’
- Distinguished because DB had no contact with the hospital at all
- Supreme Court confirmed that CTOs & conditional discharge cannot authorise a DoL
- MHA Code says leave should typically not be of a long duration & not longer than 7 days
- However, the MH casework section guidance endorses long term leave under s.17(3)

Section 117 & ordinary residence

R (Worcestershire) v SSHSC [2020] EWHC 682 (Admin)

- Under s.117, ordinary residence determined by where person was living "immediately before" being detained
- If re-detained, ordinary residence determined by where they were living before their last detention
- Government's new approach is that ordinary residence determined where person was living before their *first* detention
- Also, the deeming rules which apply under social care legislation are relevant for determining s.117 ordinary residence
- Government's arguments rejected by the High Court but subject to appeal in the Court of Appeal
- In the meantime, ordinary residence cases which raise similar issues are being stayed

General Election 2017: Theresa May promises 'sweeping' reforms to UK's mental health laws

The Tories will scrap the current Mental Health Act and bring in a new bill

The Wessely review & White Paper

- 2017 – UK government commissioned independent review chaired by Sir Simon Wessely
- Purpose was to review: (1) rising detention rates, (2) racial disparities & (3) MHA out of step with modern MH system
- Based on amending MHA – & not a new Act
- Final report published Dec 2018: '*Modernising the MHA: increasing choice, reducing compulsion*'
- Government published White Paper (Jan 2021) & response to consultation (August 2021)
- Accepted vast majority of recommendations - draft MH Bill will be introduced 'when Parliamentary time allows'

White Paper 2021

- In January 2021, Government has published its response in the form of a White Paper
- Government undertaking a 12-week consultation
- Draft Mental Health Bill will be introduced “when Parliamentary time allows”
- Based on amending the Mental Health Act 1983 – & not a new Act
- Proposals subject to future funding decisions & put forward in the context of the Spending Review

New detention criteria

- "there is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person" (ss 2 & 3)
- the purpose of care and treatment is to bring about a therapeutic benefit (s.3)
- For purposes of MHA, LD/A are not mental disorders warranting compulsory treatment (s.3)
- There must be a probable mental health cause to patient's behaviour that warrants assessment in hospital (s.2)

Advance care documents (ACDs)

- ACDs must be made when the person has capacity & set out the person's preferences about future treatment
- Only considered if the person loses the relevant capacity to make decisions about their own care and treatment
- There will be a legal requirement on clinicians to consider the ACD while they are detained under the Act
- For an ACD to be valid & have legal effect, it must have been made by someone who had the relevant capacity & apply to the treatment in question

Statutory Care & Treatment Plan

- All detained patients must have a Care & Treatment Plan, with clear expectations about how & when it will be developed with patient
- Responsible Clinician must complete & maintain the Plan, working with all others involved in the patient's care
- For section 2 & 3 detentions, the Plan must be made within 7 days of the detention
- Subject to internal scrutiny & approval by Medical/Clinical Director (or equivalent) within 14 days of detention
- They will check the Plan is sufficiently comprehensive & that the detention criteria continue to be met
- The Plan should be a living document – subject to continued dialogue with the patient & amended or adapted as required

Nominated Person (NP)

- Nearest Relative will be replaced by NP who the patient can personally select to represent them
- As part of a MHA assessment, the person will be asked to identify their NP
- Person also can identify and record their NP before detention, through their Advance Choice Document
- A person under 16, who is Gillick competent, will be able to choose a NP
- The NP will have the same rights & powers as Nearest Relatives have now

- If person lacks capacity & has not made an Advance Choice Document, an Interim Nominated Person (INP) will be appointed by an AMHP
- The INP will be in place until the person has the relevant capacity to make their own nomination
- The NP's objection to admission can be temporarily overruled, as opposed to the NP being displaced
- The Government will explore whether the power to overrule or displace a NP should instead sit within the tribunal service's remit

Mental health tribunals

- More frequent appeals – s.2 patients can apply within 21 days & s.3 can appeal three times in first 12 months
- IMHAs given right to appeal to tribunal
- Automatic referral to the tribunal every 12 months, if a referral has not been made
- Tribunals will have power to grant leave, transfer patients, for example to a less secure hospital, & to direct services in the community
- Tribunals will consider patient appeals against the provision of specific treatment categories

Consent to treatment

- ECT can only be given in face of a refusal in urgent cases with High Court approval (& 2 med recs)
- Medication – reduction of timescale for SOAD certifications (14 days for capacitous refusal & 2months for those lacking capacity)
- Medication – recognition of advance decisions
- Urgent treatment cannot be given to alleviate serious suffering by the patient

Community Treatment Orders

- CTO criteria will be changed to require a *substantial likelihood of significant harm* & *therapeutic benefit*
- The Code of Practice will set an expectation that CTOs should end after a period of 2 years
- Tribunal will check justification for conditions & recommend they are reconsidered if overly restrictive
- Recall only possible when otherwise there is a substantial risk of significant harm
- Government plans to monitor the effects of their reforms over an initial five-year period

Supervised Discharge

- Current law – conditional discharge of restricted patients cannot authorise deprivation of liberty
- Government will introduce new ‘supervised discharge’ power to enable deprivation of liberty in the community
- Applicable only to restricted patients & available irrespective of decision-making capacity
- Could be made by mental health tribunal

Has the MHA 1983 had its day?

- Mental Capacity Act (Northern Ireland) 2016 introduced “fusion law” ie capacity-based mental health treatment
- UN CRPD requires legal capacity on an equal basis and disability should not justify detention
- Law Commission recommended Government should consider introduction of fusion law (2017 DoLS report, rec 39)
- Wesseley review did not recommend fusion as it would take too long & immediate challenge was to bring MHA ‘up to date’

My contact details

t.spencer-lane@sgul.kingston.ac.uk

Thank you for listening

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