

Mental Health Act independent review

**Response coordinated by
Centre for Mental Health, Prison Reform Trust
& Together for Mental Wellbeing**

Background

Following a meeting of the Prison Reform Trust's *Care not Custody* programme, and subsequent correspondence with Sir Simon Wessely, chair of the Mental Health Act independent review, it was agreed that the Centre for Mental Health, Prison Reform Trust and Together for Mental Wellbeing would convene a small expert round table meeting to discuss criminal justice concerns as they relate to the Mental Health Act.

This paper provides a summary of main points from the discussion. It is not designed to provide a single view from attendees (although agreement was frequently reached) or definitive conclusions, rather to provide Sir Simon and the review team with thoughts and priorities for reform and ideas for how reform might be taken forward. This paper should be viewed as a starting point for discussion; attendees and their organisations welcome ongoing dialogue on these, and related issues, as the independent review progresses.

In addition to the 13 attendees at our roundtable, see below, contributions to this paper have been made by Angus Cameron, Mental Health Advisor and Head of PD Strategy Implementation, National Probation Service (London Division), Chief Constable Simon Cole (Leicestershire police), the Howard League for Penal Reform, and the Law Society.

Attendees

- Lord Bradley, seminar chair
- Ian Anderson, Care and Justice Network, Association of Directors of Social Services
- Harm Boer, Consultant Forensic Psychiatrist for People with Learning Disability, The Huntercombe Centre Birmingham
- Linda Bryant, Together for Mental Wellbeing
- Peter Dawson, Prison Reform Trust
- Graham Durcan, Centre for Mental Health
- Jo Easton, Magistrates' Association
- Kimmett Edgar, Prison Reform Trust
- Mignon French, Programme Manager, Community Sentence Treatment Requirement
- Alison Giraud Saunders, National Development Team for Inclusion (NDTi)
- Kate Morrissey, National Programme Manager: Mental Health, Secure and Detained, NHS England
- Superintendent Sean Russell, West Midlands Police Mental Health Lead
- Jenny Talbot, Prison Reform Trust

Ten main points, in summary

The following ten points summarise our discussions. Thereafter, further detail can be found under the headings: Review focus; Our focus and principles; Police powers; Criminal courts; Part III, and Wider systems and processes.

- 1. The MHA should be an enabling piece of legislation to encourage good mental health and wellbeing, with a strong focus on prevention across all public services. This, in turn, can help prevent a person's contact with criminal justice services.**
- 2. The review should consider evidence presented by the Lammy Review, that lack of trust and confidence in authorities (especially the police) may mean that young people from BAME communities are less likely to access early intervention and diversion routes. Mental health services should be better equipped – more culturally aware and pro-active – for responding to the mental health needs of BAME communities.**
- 3. There should be a clear principle of equivalence between the civil and forensic parts of the MHA – people in the criminal justice system should expect the same access to and quality of treatment and outcomes as people in the community, and the same approach to and level of safeguards. An independent panel should be established with oversight of the detention status of prisoners requiring detention under the MHA. The panel would act in the best interest of the individuals, which would help to safeguard the rights of those who are detained.**
- 4. Revisions to statutory guidance and the use of existing legislation, such as the Care Act, can minimise the need for new legislation, which may be hard to deliver.**
- 5. In considering how to respond to someone who appears to have acute mental health needs and/or is lacking mental capacity and may have committed an offence, primary consideration should be given to ensuring that their immediate needs are met. Access to places of assessment away from police custody, supported by liaison and diversion services, can help to ensure timely referrals and support, and best outcomes.**
- 6. Access to secure and specialist beds, whether for assessment or treatment and care, should be dealt with in the same urgency for individuals in the criminal justice system as for those in the wider community. Prison should not be used as a temporary solution while a hospital bed is found, neither should it be used as a place of remand while awaiting a mental health assessment; instead, s.35 of the MHA should be invoked. For those convicted, but requiring treatment, there should be a greater use of s.38.**
- 7. The MHA should explicitly state that prison is not a place of safety in the context of the Act; this has implications for the Bail Act 1976 provision to remand a person into custody for their own protection.**

- 8. The impact of the prison environment on prisoners' mental health and wellbeing should be recognised. Prisoners should expect to be accommodated in an environment that promotes their mental health and wellbeing, and at the very least does no harm.**
- 9. Greater use of Mental Health Treatment Requirements should be made; the new Community Sentence Treatment Requirements should be encouraged, and specific sentencing options developed for offenders with learning disabilities and/or autism.**
- 10. People with learning disabilities and/or autism who commit offences should not be treated less favourably by the combined criminal justice, health and social care systems. There are currently people detained in hospital for longer periods than they would have spent in prison, with no discernible clinical purpose or therapeutic benefit; to repeat our above point: specific sentencing options should be developed for offenders with learning disabilities and/or autism.**

Review focus

1. We agree with the stated aims of the independent review to address concerns about:
 - a. rising rates of detention under the MHA;
 - b. the disproportionate number of people from black and minority ethnicities detained under the MHA;
 - c. stakeholder concerns that some processes relating to the Act are out of step with a modern mental health system.
2. The independent review is an opportunity for making recommendations for a wider overhaul of the Mental Health Act (1983), which bears considerable resemblance to its forerunner of nearly 60 years ago (the 1959 Act). In considering any broader overhaul, the review team should hold fast to these stated aims. We are aware that some interested bodies see a need for extension of powers under the Act, but are concerned this may result in increased usage of detention.
3. We welcome the emphasis on co-production, and that the review will closely involve service users and carers in all aspects of its work.

Our focus and principles

4. As a group formed because of our collective interests in the criminal justice and mental health systems, our focus is on the aspects of the Mental Health Act (MHA) that have application for people in contact with the criminal justice system.
5. We welcome the review's focus on practice-based solutions rather than just legislation, which was reflected in our discussions and in this paper. This might mean consideration of changes to the MHA Code of Practice, as well as other relevant statutory guidance and wider support to frontline professionals in its application. It is important that the review should consider the impact of other relevant legislation such as the Mental Capacity Act 2005 the Care Act 2014 and

the Bail Act 1976, and how these interact with the MHA. It is also important to consider the European Convention on Human Rights and the United Nations Convention on the Rights of Persons with Disabilities, in particular Article 14:

“1. States Parties shall ensure that persons with disabilities, on an equal basis with others

- a) Enjoy the right to liberty and security of person;*
- b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.*

2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of the present Convention, including by provision of reasonable accommodation.”

6. It is important to consider how the availability and effectiveness of other health and social care services are likely to have implications for the way in which the MHA is applied, and the way in which people are supported. The review must take this into account, as well as considering the impact of the MHA itself, alongside the principles listed at paragraph 7, below.
7. Our consideration of the MHA and reforms to it, its guidance, practice and other relevant reforms, is based on the following principles:
 - a. The rights of the individual are foremost; detention under the Act is, and should always be, the last resort, and individuals should be held in the least restrictive setting;
 - b. Deprivation of liberty under the Act should be for the shortest period possible;
 - c. Those with the power of detention under the Act should be clear about the purpose of detention and be able to demonstrate that there is no alternative;
 - d. There should parity of esteem, including timely access to and quality of support and treatment, between people in the community and people in the criminal justice system;
 - e. Legislation should not be used ‘fill other gaps’, e.g. extending certain powers to address poor service responses or shortages in resources;
 - f. That all public services have a role to play in promoting positive mental health and wellbeing, including the police, criminal courts, probation and prisons, and to intervene early, rather than at the point of crisis.

Police powers

8. Police powers under the MHA pertaining to s.135 and s.136 and the guidance documents for England and Wales have been subject to recent review and amendment (2017). These include revisions to the definitions of private premises. However, there remains dissatisfaction, particularly powers concerning s.135 and the use of police cells as a place of safety.

9. We agree that police cells should never be used as a place of safety for people undergoing what is a health crisis. However, currently this imperative can result in a detained person remaining in a police vehicle (arguably considerably less desirable than a police cell) for a lengthy period while a health-based place of safety is sought.
10. We do not see this as an argument for allowing police cell usage more often, even if as a 'last resort', but rather an argument that health services take on more responsibility for the 'patient'/detainee from the point of detention. This might mean the NHS centralising (at least within a region or other area) the finding of a health based place of safety. Further to this we see it as a responsibility for NHS commissioners to adequately contract ambulance vehicles so that they can make a timely response. These comments apply to both s.135 and s.136.
11. In Birmingham, individuals in crisis are taken straight to a 'Psychiatric Decision Unit', bypassing police custody. An assessment helps determine the most appropriate course of action, from access to primary care through to detention under the MHA – and, where necessary, involvement with the police remains an option. The Psychiatric Decision Unit is located next to the s.136 suite, and also supports voluntary attendance.
12. The review team may wish to further explore this, and similar examples (such as Newcastle, which has a more system wide approach), and consider the development of national guidance and principles. Liaison and diversion services are an integral part of the 'pathway', from first point of contact with the police, and could play an important role in coordinating referrals to and responses from local services.
13. Concerning s.135, there are stated concerns, particularly from police representatives, that police have difficulties in removing an individual from private premises. Many of the examples cited appear to relate to the responsiveness of other professionals and their ability to respond, such as Approved Mental Health Professionals, doctors, and ambulance staff.
14. We do not see this as a failure primarily in the current legislation. Rather, we see the solution in defining the responsibility of other services and ensuring they are adequately resourced (and commissioned) to respond. It was highlighted that often police and health services are responding to the same individuals, and that better information sharing, and coordination would support a more preventative approach.

Criminal courts

15. Information about a defendant's mental health should be made available to the court at their first appearance, so that decisions are made in full understanding of their needs. Liaison and diversion services have a key role to play here, without which such information is unlikely to come routinely before the courts.
16. The speed at which courts are required to operate can conspire against gathering information about a person's condition, particularly at first hearing and especially from family members (with the necessary permissions and safeguards). Where an accused person has, or might have,

a mental disorder, proceedings should be slowed down and courts should have the confidence to do this within the Criminal Justice 'SSS' approach (Simple, Speedy, Summary).

17. Concerns were raised about accused persons being remanded into custody for a mental health assessment. The suggestion was made that no-one with a suspected mental health condition should be remanded into custody without first having undergone a mental health assessment to determine their level of need, and whether prison is appropriate. Prison is neither safe, nor a place of safety (see paragraph 21), and individuals should not be remanded into custody for a mental health assessment. Where a mental health assessment is deemed necessary, two options are available:
 - a. The roll-out of liaison and diversion services means that assessments can be undertaken in a timely way; but there will be occasions when services are not operating at the time as courts, such as at weekends
 - b. s.35 of the MHA should be used: 'Remand to hospital for report on accused's mental condition.' S.35 is, however, rarely used – a lack of beds, and length of time taken to make arrangements being two possible barriers.

18. In similar vein, concerns were expressed about use of the Bail Act 1976 to remand individuals into custody for their own protection, especially when they have, or might have, a mental disorder. The courts need an alternative when there are concerns that a defendant presents a real and immediate risk of self-harm.

19. High numbers of offenders have mental health conditions, and yet only a tiny proportion of Mental Health Treatment Requirements (MHTRs) are made as part of a community sentence. A pilot in Milton Keynes has demonstrated that MHTRs can be put in place, in a timely way, with good results – both in terms of reduced reoffending and improved health and wellbeing outcomes. Further trial sites are welcomed, and it is hoped that MHTRs, including options for offenders with learning disabilities and/or autism, will become more readily available nationwide. To support this work, NHS England and CCGs should ensure provision is reflected in contracts with Mental Health providers.

20. Concerns exist whereby individuals with high harm/high risk offending and mental health needs at the time of sentencing may be discharged from section under the MHA (appropriately, once treatment has been completed), but who may continue to pose a high risk for further similar offending. In cases such as these, consideration should be given to the 'drivers' for the offending. For example, if the main driver was psychosis then the appropriate outcome would be diversion from the criminal justice system and treatment in hospital. If, however, the risk exists 'outside' of the mental health condition, a prison sentence might be the most appropriate disposal. More consideration should be given by the court (and medical assessors) to s.45a of the MHA, a Hospital Direction Order. S.45a allows for the person to be sentenced for the offence, but directed to hospital without going to prison. The person may serve part, or all of their sentence in hospital; but once treatment is no longer necessary, they may be taken to prison to serve the remainder of their sentence, and decisions about release are taken by the Parole Board. There are safeguards in this provision in that the sentencing judge must consider if

a Hospital Order is a more appropriate disposal, and it cannot be used in cases where there is diminished responsibility. S.45a is infrequently used, and knowledge of it in both criminal justice and mental health services seems limited.

21. Weekend courts should have equivalent access to health services, including for mental health assessment and liaison and diversion services, as courts sitting mid-week.

Part III of the Mental Health Act

People being sent to prison

22. Prison is not a place of safety: the MHA should explicitly state that prison is not a place of safety in the context of the Act. This would suggest amendments to the Bail Act 1976, which permits remand of people to prison for their own protection. The risks inherent in custody should be better understood, and this might inform training packages.
23. Reasonable adjustments should be made to the prison environment to ensure the needs of prisoners with disabilities, including certain mental health conditions, are anticipated and met. There will be times, however, when the intrinsic characteristics of prison cannot be adequately 'adjusted', and an alternative place should be found.
24. There is merit in considering a proposal for a new administrative power, by which the head of healthcare in each prison is authorised to turn away people whose lives may be put at risk by the inherent characteristics of custodial institutions. The proposal would address the exceptional circumstances where the state's duty to uphold the right to personal security requires an alternative to custody. That alternative should be determined by the specific and immediate needs of the person concerned, and might involve, for example, home detention (where appropriate) or crisis care in a psychiatric unit.
25. A 'no blame' mechanism should be established to expose decision making that leads to inappropriate imprisonment of individuals with mental health conditions, so that lessons can be learned and disseminated. Similarly, good practice should be shared.
26. An independent panel should be established with oversight of the detention status of prisoners requiring detention under the MHA. The panel would act in the best interest of the individuals, which would help to safeguard the rights of those who are detained.

Transfers from prison into secure care

27. Transfer from prison under the Mental Health Act remains problematic, and reviews have reported lengthy delays for people who are acutely ill. There are a number of reasons for this, including:
 - a. Shortage of forensic secure care resources, including 'specialist' beds for, for example, people with learning disabilities and/or autism;

- b. No overarching commissioning framework for forensic secure and specialist beds, and additional challenges in accessing a bed out of region;
 - c. Confusion/lack of consistency in how the 14-day transfer 'rule' is applied;
 - d. Multiple assessments (psychiatry, nursing, discussion with MDT);
 - e. Delays on Ministry of Justice sanctioning transfers;
 - f. Risk aversion.
28. Transfers for women and children (<18 years of age) can be even more problematic. Women and children represent minority groups within the prison estate and, as such, are often held far from home. These long distances are frequently replicated when secure or specialist beds are sought, making it hard for family ties to be maintained.
29. A single competent assessment should be undertaken and, if transfer under the Act is deemed necessary, the individual should be found the nearest available bed, at an appropriate level of security. Many prisons have within their mental health staff teams adequately qualified and experienced forensic psychiatrists¹ who could provide a competent assessment that would demonstrate the need for transfer and at what level of security. Another option might be to have a locally commissioned rota of psychiatrists to provide rapid response as needed.
30. The transfer rule (14 day) 'clock' should commence from the moment a formal referral for assessment for transfer is made. It is reported that some prisoners have considerable waits for assessment.
31. Unlike Part II of the MHA, there is no description of urgency in Part III or in the Code of Practice. This can lead to people in prison being segregated and placed on constant watch while awaiting transfer. Being held in such conditions will be, for most people, exacerbating factors in any deterioration of their mental wellbeing. This is an area where reform of the Act itself should support parity of esteem between people in the community and people in the criminal justice system. (For example, for individuals in a community setting, s.140 MHA allows CCGs to commission emergency beds when a person is deemed to require an admission under S2/S3 MHA, but where no formal admission bed space is identified. An equivalent process should be available for NHS England, enabling them to commission emergency beds for offenders in need of assessment and/or treatment, to prevent their being imprisoned due to a lack of mental health resources.)

Release from prison

32. Prison Governors should be responsible for ensuring that prison health and social care providers are alerted at the earliest opportunity of any individual due to be released from custody who may require ongoing care and support. To this end, we might look to replicate provisions under the Care Act for people who move between local authorities, to NHS England and the local authority where the prison is located to make them responsible for securing the aftercare support until such time as they have notified the receiving CCG and/or local authority and

¹ Their expertise may not, however, include learning disabilities and autism, and additional input may therefore be necessary.

allowed them a reasonable (shorter rather than longer) period to make arrangements to assume responsibility.

Other issues – prison

33. The practice of ‘gate arrest’ or ‘gate detention’ is highly objectionable and should be stopped. There are numerous examples where the early or unexpected release of a person who is mentally unwell in prison is generating a police response to gate detain under s136 MHA. The health and justice system should coordinate an earlier assessment process or create an expedited urgent assessment in custody process.
34. Crisis intervention in prison should be available 24/7 to support both individual prisoners, as necessary, and the staff who work with them. NHS England are looking to address this in their new mental health specification, and the principle should be restated in MHA guidance.
35. More generally, the impact of the prison environment on prisoners’ mental health and wellbeing must be considered. For example, an increase in the use of longer sentences and an ageing population can place individuals at particular risk. At a very minimum, prison should have a neutral effect – as in not causing a person any harm.
36. Some prisons are considering ‘enhanced units’ for prisoners who find the prison environment especially hard to bear and who need more ‘intensive’ support and care than currently provided by prison healthcare units. We do, however, have major concerns about separate units within prison being used as a substitute for hospital care.
37. Prison managers, including governing Governors, should participate in mental health awareness training, which should include different mental health conditions, the impact of detention on mental health, and the legislative framework of which the MHA forms a part.

Wider systems and processes

38. The interactions between the Mental Health Act and the criminal justice system are important means of ensuring that patients receive the treatment they require, and public safety is upheld. Their use, however, is often a result of gaps in prevention and early intervention that might have reduced the risk of a person requiring a criminal justice response to a health problem.
39. There is growing evidence about the benefits of earlier intervention to prevent the escalation of mental health difficulties and its association, in a small proportion of cases, with violence and offending. The MHA independent review has the opportunity to make recommendations about changes that can be made to reduce the risk of an individual becoming so unwell as to come into contact with the police because of their mental health. These may include:
 - a. Preventive interventions during childhood: for example, parenting programmes to prevent or mitigate severe behavioural problems;
 - b. Early Intervention in psychosis: to ensure that anyone experiencing a first episode of psychosis gets help within two weeks;

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- c. Action to address inequalities in teenage years: for example, to reduce the risk of school exclusion among young black men;
 - d. Improved coordination between substance misuse and mental health services: to address the significant impact of alcohol and drugs on offending among people with mental health difficulties.
40. The benefits of liaison and diversion services are significant in the early identification of individuals with mental health conditions, and other needs, when they first come into contact with the criminal justice system. Their assessments inform criminal justice decision making and reasonable adjustments (where necessary), and their knowledge of local services can help to secure much needed support. Services are currently available across 83% of the population, and should reach 100% by 2019/20.
41. The Lammy report provides the review team with a good basis to look at how local services can work together, alongside service users, to improve outcomes. The report outlines how lack of trust and confidence in authorities (especially police) amongst young people from BAME communities, and the role the police play in diversion to health settings, may mean that they are less likely to access health interventions than other young people.
42. The Lammy report includes suggestions about increasing cultural competence and using lived experience. These could be reflected in guidance to support the MHA.
43. The Care Act 2014 enshrines the key principles of prevention, personalisation and integration. Clinicians will be familiar with the MHA, but perhaps less so with other relevant legislation. Drawing on existing legislation, such as the Care Act, and revising statutory guidance, could minimise the need for new legislation.
44. In similar vein, aligning different elements of legislation, such as s.117 MHA (after-care responsibilities) with the Care Act (transferability of responsible local authority) as they apply to people in prison would be helpful. For example, a person receives treatment under s.117 based on where they were resident when detained, which may mean they find it hard to access necessary aftercare on their release, or that 'packages' of treatment and care are slow to arrange, or fragmented. Assessments that determine a person's eligible social care needs, however, 'follow' the individual as they transfer between institutions or upon their release back into the community, and are taken on by the receiving local authority adult social care service.
45. Another example illustrating a need for improved alignment is the March 2017 Court of Appeal judgement in the case of MM. This raises questions about the interaction of the MHA, the Mental Capacity Act, and criminal law. The current position appears to be that:
- a. people sentenced to prison may be released under conditions (imposed by the courts) that restrict their liberty if they are still perceived as posing a risk to the public
 - b. people detained in hospital under the MHA who lack capacity to make the relevant decisions about their care and treatment may be discharged from hospital under similarly restrictive

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conditions, using best interest decisions and Deprivation of Liberty Safeguards under the Mental Capacity Act

- c. people detained in hospital under the MHA who do have capacity to make the relevant decisions about their care and treatment may not have such restrictions imposed under the MHA, and risk being detained until they are assessed as 'ready' for discharge, even if they are deriving no therapeutic benefit from continued hospitalisation, and skilled community services could manage them safely, with restrictions.

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