

## **Mental Health Act independent review: learning disability and autism**

**Response coordinated by the Prison Reform Trust on behalf of:  
Centre for Mental Health, Prison Reform Trust  
& Together for Mental Health**

### **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 Health would convene a small expert round table seminar to discuss criminal justice concerns as they relate to the Mental Health Act. A seminar was held on 10 January, and a consultation response was submitted on 17 January. At a follow up meeting with Sir Simon and one of his vice chairs, Sir Mark Hedley, we were asked if we would repeat the exercise with a specific focus on learning disability and autism, and a second seminar was held on 18 April.

This paper provides a summary of main points from our second seminar. 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.

The focus and principles underpinning this response are the same as for our January submission, a copy of which is at Appendix 1 (see paragraphs 4-7).

In addition to the 15 attendees at our seminar (see below), contributions to this paper have been made by Harm Boer, Consultant Forensic Psychiatrist for People with Learning Disability, The Huntercombe Centre, Birmingham, and Glynis Murphy, Professor of Clinical Psychology and Disability, The Tizard Centre, University of Kent.

We are grateful to Lord Bradley for chairing this, and our January seminar.

### **Attendees**

- Lord Bradley, seminar chair
- Salma Ali, Central and North West London NHS Foundation Trust
- Amy Brody, Mental Health Act independent review team/Department of Health
- Zoe Burton, Prison Reform Trust (meeting support and note taker)
- Peter Dawson, Prison Reform Trust
- Jo Easton, Magistrates' Association

- Tracy Hammond, Learning Disability England and KeyRing Living Support Networks
- Andrea Hollomotz, School of Sociology and Social Policy, University of Leeds
- Amanda Keeling, University Academic Fellow in Disability Law, University of Leeds
- Danielle Kenny, Senior Probation Officer, National Probation Service
- Sarah Lambert, National Autistic Society
- Ben Lumley, Mental Health Act independent review team/Ministry of Justice
- Alison Giraud Saunders, National Development Team for Inclusion (NDTi)
- Zandrea Stewart, Local Government Association and ADASS lead on autism
- Jenny Talbot, Prison Reform Trust

### Questions posed by the independent review team

Prior to the seminar, the independent review team posed three main areas for our discussion; these were:

- Whether it is appropriate that the Mental Health Act includes powers in relation to people with learning disabilities and/or autism
- Practical suggestions, ideas and recommendations around how people with a learning disability and/or on the autism spectrum could be better supported in relation to the Mental Health Act. For example, this might include training, awareness and appropriate screening and assessment
- Wider views/recommendations beyond Part III of the Mental Health Act.

### Main points

Questions posed by the independent review team were addressed in turn. The following points summarise our discussions; they relate specifically to people with autism and people with learning disability and supplement our January submission, the content of which applies also to this group (see Appendix 1).

- **Is it appropriate that the Mental Health Act includes powers in relation to people with learning disabilities and/or autism? (And additional points that relate directly to the Mental Health Act.)**
1. **Most seminar participants were uncomfortable that a lack of support and services for people with a learning disability and/or on the autism spectrum could be considered reason enough to keep both conditions within the scope of the Mental Health Act.** Concern was, however, expressed that in removing them from the Act, no other system was in place able to provide an immediate and effective alternative. See point 21 for our recommendations to review care and support for autistic people and people with a learning disability.
  2. **People on the autism spectrum and people with learning disability should not be detained under the Act on the grounds of disability alone.** The requirement in the Act for a person with a learning disability to display ‘abnormally aggressive or seriously irresponsible conduct’

should also apply for people with autism. What constitutes ‘abnormally aggressive or seriously irresponsible conduct’ can be open to interpretation; the Mental Health Act Code of Practice should be revised to include clear guidance for professionals.

3. **Learning disability and autism are different conditions** and should not be conflated; it should, however, be recognised that co-morbidity of learning disability and autism is not uncommon.
4. **Learning disability and autism are spectrum conditions**, and different responses will be necessary according to the nature of the condition. For example, individuals may be supported through the criminal justice system or require interventions in other settings. During our discussion, four groups were identified as exemplars of this diversity:
  - a. a person with mild learning disability *or* on the autism spectrum who does not have a mental illness, where there is no role for the Mental Health Act in the absence of ‘abnormally aggressive or seriously irresponsible behaviour’
  - b. a person with learning disability *or* autism who does have a mental illness, in which case the Mental Health Act may be appropriate on the grounds of their mental illness
  - c. a person with learning disabilities and autism, where there is no role for the Mental Health Act in the absence of other problems (mental illness and/or abnormally aggressive or seriously irresponsible behaviour)
  - d. a person with more significant learning disabilities who may lack capacity to make some decisions about their behaviour and/or care or treatment, where there is no role for the Mental Health Act in the absence of other problems (mental ill health and/or abnormally aggressive or seriously irresponsible behaviour).
5. **Section 37/41 (restriction order), and 47/49 transfers:** individuals with learning disability or autism can face the risk of being detained for long periods of time, without prospect of discharge if they haven’t (sufficiently) responded to treatment to be released unsupervised into the community or are deemed to present a risk of harm following the conclusion of treatment. According to one of our contributors, these individuals can be divided into three groups:
  - a. Those who would comply with supervision on discharge but for whom the law, as it stands, makes no such provision; i.e. there is no power that can be exercised by the Tribunal to authorise a patient’s deprivation of liberty outside hospital, as there is no existing statutory authority for this within the Mental Health Act either express or implied<sup>1</sup>.
  - b. Those who would not comply with supervision on discharge, and who should therefore remain detained in a suitable setting
  - c. A smaller number who have cognitively, mentally or physically deteriorated to the point where they need constant supervision – for those reasons – and where it is clear that this will be a lifelong condition. In such circumstances it may be argued

---

<sup>1</sup> See, for example, the case of MM: <https://www.serjeantsinn.com/wp-content/uploads/2017/03/C320154104-C320160561-29-03-17.pdf>

that, as the patient will need supervision for other reasons they can be safely discharged, even if there could still be a risk to others if the patient were allowed to be without escort in the community.

Alternative provision should be made for those in groups 'a' and 'c'. One proposal is for individuals to be released into the community under supervision, with the scope to restrict known problematic behaviours and recall if conditions are breached. This could be akin to a Community Treatment Order, enhanced to accommodate conditions that are often applied to those on licence, such as prohibited contact and residency curfew. Despite the complex ethical concerns associated with additional requirements of this nature, this proposal offers a better outcome than lifelong detention without any prospect of release.

6. **Guardianship order:** although little used, Guardianship orders can provide necessary support and supervision, while enabling the person to remain in the community, and could be combined with a community sentence (see points 11 and 14). Evidence shows that people with learning disability and/or autism best learn to change their behaviour where they can take managed risks and apply learning in their own 'world'/local community. However, the interface between Guardianship and Deprivation of Liberty Safeguards (DoLS) can be complex<sup>2</sup>.
- **Practical suggestions, ideas and recommendations around how people with a learning disability and/or on the autism spectrum could be better supported in relation to the Mental Health Act.**
7. **Screening and, where necessary, assessment** for learning disability and for autism should be routinely undertaken when a person first comes into contact with the criminal justice system (i.e. when detained by the police or subject to a voluntary interview); liaison and diversion services are well placed to undertake this role. Information should be shared appropriately and proportionately with health, social care and criminal justice services, and the person's needs should be identified and met. Where a more detailed assessment is necessary, s.35 of the Mental Health Act should be invoked (point 6, Appendix 1; and section 7.16 (page 45) of the interim report of the independent review of the Mental Health Act (May, 2018), refer).
8. **Improved data collection:** data from routine screening/assessment (point 7) should be collected and collated nationally to provide a clear picture of how many people there are with learning disability and/or autism at each stage of the criminal justice process (police, courts, prison and probation), and should include people on remand or in hospital waiting for an assessment. This would help provide a better understanding of the forensic, and other needs of these individuals and inform future working.

---

<sup>2</sup> See, for example: <http://www.publiclawtoday.co.uk/local-government/public-health/174-healthcare/25354-guardianship-and-dols-again>

9. **Information and awareness training** for learning disability and for autism should be mandatory for all front-line health<sup>3</sup>, social care and justice personnel who come into contact with adult suspects, defendants, offenders and prisoners, and at least one member of each organisation's senior management team. Information and awareness training should include relevant sections of the Mental Health Act, the Mental Capacity Act, the Care Act, the Autism Act and the Equality Act. Awareness training should be multi-agency and be organised at the local or regional level. Ideally autistic people and people with learning disability should be involved as co-trainers. Ill-informed (but well intentioned) responses to individuals with learning disability and/or autism may contribute to the increased likelihood of 'abnormally aggressive and irresponsible behaviour', so increasing the risk of a person being detained under the Mental Health Act.
10. **Information and awareness training about the range of criminal justice options available under Mental Health Act should be enhanced and made mandatory for members of the judiciary**, and especially magistrates. In particular, the criminal courts should receive, and seek out, up to date information about options for community disposals, such as the Community Sentence Treatment Requirement (CSTR), in their local area.
11. **Offenders with a learning disability and/or autism should be able to access a similar range of sentencing options and intervention as offenders without a disability.** Community sentencing options, including treatment requirements<sup>4</sup>, should be routinely available nationwide. Where these do not exist, or are inadequate, a formal mechanism should ensure that this is brought to the attention of relevant commissioners, and the necessary arrangements put in place. A Learning Disability Intervention Requirement, akin to the Mental Health Treatment Requirement, should be considered, and delivered by local Community Learning Disability Teams.
12. **Reasonable adjustments** for learning disability and/or autism should be anticipated and developed across the criminal justice pathway and adapted to meet the particular needs of each individual. 'Special measures', including access to intermediaries for the accused, should be made statutory (and equitable with access to intermediaries for victims and witnesses). The use of accessible information, such as 'easy read' should be mandatory for criminal justice information of particular significance to the offender; for example, bail and licence conditions.
13. It is important to consider how the availability and effectiveness of health and social care services are likely to have implications for the way in which the Mental Health Act is applied, and the way in which people are supported. **Neither detention under the Mental Health Act nor the criminal justice system should be used to plug gaps in community services.** There is growing evidence that intervening early can help prevent the escalation of challenging and

---

<sup>3</sup> Including registered medical practitioners approved for the purposes of section 12 of the Mental Health Act.

<sup>4</sup> Drug Rehabilitation Treatment Requirement (DRR), Alcohol Treatment Requirement (ATR) and, for offenders with learning disability and/or autism who also have a treatable mental health condition, Mental Health Treatment Requirement.

offending behaviours by people with learning disability and/or autism. And yet, accessing support can be especially hard for people with a mild learning disability and people on the autism spectrum who don't also have a learning disability. Gaps in services can increase the risk of a criminal justice response to a health or social care need. People with learning disabilities or autism who come into contact with the criminal justice system, or who are at risk of doing so, are:

*'...often excluded from mainstream mental health or forensic services because of their learning disability and/or autism, and excluded from learning disability services because they are considered too able or too high risk, or because they have autism but do not have a learning disability'* (NHS England, 2017:25).

Thresholds to access support should be flexible and based on need. Contact and risk of contact with criminal justice services should trigger a review of need and community-based support; see point 14. During our seminar, an example to demonstrate this point was given; see box 1.

**Illustrative study, box 1:**

The young adult has a long history of inappropriate on-line behaviour and is addicted to social media; he has autism and is thought to have learning disabilities. He lives with his parents; his mum is an alcoholic. He receives no support. When he was first convicted I recommended support; none was given as neither Social Services nor the Community Learning Disability Team would accept him as eligible. He re-offended; I re-recommended support (more of it), but none was given. He has now re-offended again. Social Services and the Community Learning Disability Team have done next to nothing. I am tempted to recommend an NHS secure unit or A&T unit on MHA section, as then he would get some support; but I really feel community services should accept him and support him.

14. Building on point 13., **there is merit in considering a new mandatory requirement for health, social care and justice agencies to work together to develop the necessary package of personalised intervention and support when a person with learning disabilities and/or autism first comes to the attention of the police.** An identified 'responsible officer' would coordinate the process and identified agencies would have a 'duty to cooperate', so ensuring integrated multiagency support around the individual. A 'key worker' could help to ensure the person's engagement with services, and act as an advocate with service providers, as required. Evidence shows that dedicated key worker support, and the building of a relationship of trust, can be especially effective for people in contact with criminal justice services. This arrangement would work in tandem with liaison and diversion services, inform criminal justice decision making (for example bail and bail conditions, charge and prosecution, diversion away from the criminal justice system), and ensure best outcomes for the individual without circumventing the criminal justice process, and would run concurrently with it<sup>5</sup>. During our seminar, two examples were given where this arrangement could have avoided detention under the Mental Health Act; see boxes 1 and 2.

<sup>5</sup> During our seminar, MAPPA was used as an example to demonstrate mandatory multi-agency cooperation.

**Illustrative study, box 2:**

A man with learning disabilities was sentenced to a hospital order. He was involved in local criminal and substance using subcultures, which contributed to a chaotic life style and made him vulnerable to exploitation. At no point during criminal justice proceedings were the views of the National Probation Service sought. On hearing about the case, it was the view of the senior probation officer that, with careful consideration of the risks involved, and working together with learning disability services, adult social care and the local drug service, a community sentence underpinned by an effective risk management plan could have avoided his detention under the Mental Health Act.

- **Wider views/recommendations beyond Part III of the Mental Health Act.**

15. **Prevention and early intervention:** many people with a mild learning disability and/or autism find it especially hard to access services (see point 13). They are frequently underserved by health and social care services and, in the absence of timely support, the personal and financial costs of contact with criminal justice services, crisis intervention and hospitalisation can be high. The Care Act, the Autism Act and Transforming Care enshrine the principles of prevention, early intervention, personalisation and integration. Existing legislation and national policy, underpinned by revised statutory guidance, would help ensure necessary support based on need. This, in turn, would help to prevent possible deterioration in a person's ability to cope with their daily living and escalation of anti-social/challenging behaviour, and reduce contact with criminal justice services and/or risk of secure care.
16. **Accessible information:** there is a need to simplify the main provisions of the Mental Health Act, making it accessible and jargon free. This is of particular importance for those who come within the scope of the Act, and their family members and carers, but also for practitioners, professionals and members of the judiciary who might be less familiar than clinicians are about its content and purpose. The rights of those subject to the Mental Health Act, including right of appeal, should be made available in accessible format.
17. **Appropriate Adults:** there is no statutory provision of Appropriate Adults (AA) for adults with learning disability or autism when questioned or detained by the police. This means that individuals can be detained for long periods while an AA is located, adding further to the stress of police detention. Further, AAs may not be trained to support a person with learning disability or autism. Organised AA services exist in roughly half of England and Wales; evidence suggests that police are five times more likely to secure an AA where organised services exist. Around 22% of adults detained by the police are 'mentally vulnerable' and, according to police data, 3% get an AA<sup>6</sup>. The provision of AAs for adults with

---

<sup>6</sup> National Appropriate Adult Network; website accessed 27 April 2017:  
<http://www.appropriateadult.org.uk/index.php/policy/vulnerable-adults?highlight=WyJyZXNIYXJjaCIsInJlc2VhcmNoZXJzIiwicmVzZWZyY2hpbmciXQ>

autism or learning disabilities (and certain mental health conditions) should be made statutory, and the agency responsible for ensuring provision clarified.

18. **Information provided by liaison and diversion services** to justice personnel (police, CPS, criminal courts, probation – including pre-sentence reports, and prison) and members of the judiciary should include how a person’s learning disability or autism affects their behaviour, the likely impact on their daily living, and what reasonable adjustments should be made to ensure their effective participation in justice proceedings.
19. **Women:** little is known about women with learning disabilities in contact with, or on the edges of the criminal justice system, and even less is known about women with autism. While there is no reason to consider that their social profile will be very different to most women in the justice system, for example, poor mental health, alcohol and/or drug misuse problems, and having been a victim of physical, sexual and/or domestic abuse, more research is necessary to ensure that the particular needs of this group are recognised and met by health, social care and justice services.
20. **Independent Mental Health Advocates (IMHAs):** during our seminar the question of IMHAs for people with autism or learning disability was raised, and only a few seminar members had experiences upon which to draw. Comments received were that:
  - a. IMHAs are often not involved for people with a learning disability or autism. This can lead to family members advocating, who may have little experience or understanding of the Mental Health Act and whose interests may conflict with the person concerned
  - b. Few IMHAs have adequate knowledge and understanding of learning disability and autism
  - c. Where IMHAs do get involved, it’s time-limited, with little opportunity to get to know the person or to understand how to communicate effectively with them; see box 3.

**Illustrative study, box 3:**

We have had some feedback from families about where IMHA isn’t working for their relatives [with a learning disability]. Examples are where the advocate takes ‘instruction’ that the person doesn’t want an advocate, where they probably lack capacity to instruct and which ultimately means their rights under the Mental Health Act aren’t being upheld; for example, not applying for tribunal when they could.

21. We welcome this independent review. It is, however, small in scope and time, and recommend a **wider overhaul of the Mental Health Act**. We are concerned about compliance of the Act with UNCRPD and the need to harmonise the Act better with the Mental Capacity Act. We, therefore, further recommend a **thematic review, in line with UNCRPD, of how children and adults with learning disability and/or autism should be supported to live independent and productive lives in the community**. The review should seek to ensure necessary support throughout a person’s life, a reduction in the need for crisis care, and alternatives to detention.



**Response coordinated by the Prison Reform Trust, on behalf of the Centre for Mental Health, Prison Reform Trust and Together for Mental Wellbeing.**

Contact: [jenny.talbot@prisonreformtrust.org.uk](mailto:jenny.talbot@prisonreformtrust.org.uk)

9 May 2018

## **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 psychiatrists<sup>7</sup> 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

---

<sup>7</sup> Their expertise may not, however, include learning disabilities and autism, and additional input may therefore be necessary.

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 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;
  - 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 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.

**Response coordinated by:**

**Centre for Mental Health, Prison Reform Trust, and Together for Mental Wellbeing**

Contact: [Jenny.talbot@prisonreformtrust.org.uk](mailto:Jenny.talbot@prisonreformtrust.org.uk)

17 January 2018