

Submission of written evidence by VoiceAbility to the Joint Committee on Human Rights: Mental Health Act reform

About VoiceAbility

VoiceAbility¹ is a registered charity in England and Wales (1076630) and Scotland (SC050036) and one of the UK's largest providers of advocacy and involvement services. We have been supporting people to have their say in decisions about their health, care, and wellbeing for almost 40 years.

VoiceAbility supports people to be heard in decisions about their health, care, and wellbeing. We believe everyone has a right to:

- be heard and respected
- have the same choice, control, and freedom as any other person
- be safe from violence, discrimination, harm or abuse

VoiceAbility's Independent Mental Health Advocates (IMHAs) work in over twenty local authority areas in England and supported over 5,000 people in 2019/20 under the provisions of the Mental Health Act.

Mental Health Act reform

The Mental Health Act engages several articles of the European Convention of Human Rights and the Human Rights Act including Article 3 (right not to be tortured or treated in an inhuman or undignified way), Article 5 (right to liberty and security), Article 8 (respect for private and family life) and Article 14 (protection from discrimination).²

We welcome this legislative scrutiny and hope the Committee will be active in shaping reform of the Mental Health Act as new legislation comes before parliament. In this submission, we focus on four areas where the government's proposed reforms of the Act could improve human rights safeguards:

1. An enhanced right to advocacy for both detained and voluntary patients on an opt-out basis
2. Reform of Part III to protect the human rights of patients in the criminal justice system
3. A more comprehensive response to improve support for people with a learning disability and autistic people
4. Safeguarding human rights at the MHA/MCA interface

¹ For more information about VoiceAbility, visit www.voiceability.org

² As taken from European Convention of Human Rights and the Human Rights Act 1998

An enhanced right to advocacy for both detained and voluntary patients on an opt-out basis

When you find yourself in hospital detained and treated against your will, life upended, having an advocate to help you understand and exercise your legal rights is vital.³ IMHAs help people to navigate a complex system at one of the most difficult times of their lives, to participate in decision-making about their care and treatment and initiate Tribunal challenges when they want to. However, only a minority of psychiatric in-patients currently get support from an IMHA and the government's white paper is equivocal on improving this situation.

For those who are detained, access to an advocate is overly dependent on the discretion of the care and treatment provider. The existing legal obligations under section 130D of the Act, for providers to inform people about their right to advocacy, is far too weak and the recent experience of the pandemic has demonstrated that. The most recent Care Quality Commission (CQC) monitoring report on the Act "found wards where staff did not routinely refer any eligible patients to an IMHA, even where the patient lacked capacity to do so themselves. In the physical absence of the advocate on the ward, this effectively undermined some patients' right to advocacy at a very vulnerable time."⁴ The CQC concluded that "these experiences reinforce our view that the law should be able to compel services to refer patients to advocacy immediately on admission, and that the service should run on an 'opt-out' basis. This was recommended by the Independent Review of the MHA and we hope to see it taken up in future reform."⁵

For the half of all psychiatric in-patients who are voluntary or informal patients, if you are in Wales you have a legal right to an IMHA but in England you do not. In its report on the detention of young people with learning disabilities and/or autism in October 2019, the Joint Committee on Human Rights concluded that:

"The rights of individuals and their families to advocacy must be enhanced and enforced, including for those who are considered to be informal patients."⁶

The forthcoming reform of the Mental Health Act should include an enhanced legal right to advocacy for both detained and voluntary patients on an opt-out basis. It should legally oblige providers to notify the relevant advocacy service as soon as a patient is admitted and facilitate contact by an advocate so they can explain the service and the patient can then decide whether to take this up.

Reform of Part III to protect the human rights of patients in the criminal justice system

The white paper gives insufficient attention to reform of Part III of the Act and the need to consider the human rights of forensic patients, (those who come under the Act via the

³ [Reforming the Mental Health Act - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/consultations/reforming-the-mental-health-act) p.53

⁴ [Monitoring the Mental Health Act in 2019/20: The Mental Health Act in the coronavirus \(COVID-19\) pandemic | Care Quality Commission \(cqc.org.uk\)](https://www.cqc.org.uk/publications-reports/monitoring-the-mental-health-act-in-2019-20) p.53

⁵ [Monitoring the Mental Health Act in 2019/20: The Mental Health Act in the coronavirus \(COVID-19\) pandemic | Care Quality Commission \(cqc.org.uk\)](https://www.cqc.org.uk/publications-reports/monitoring-the-mental-health-act-in-2019-20) p.56

⁶ [Detention of children and young people with learning disabilities and/or autism \(parliament.uk\)](https://www.parliament.uk/publications/2020/10/10) p. 31

criminal justice system), alongside issues of public protection. If this important part of mental health law is left relatively untouched, it risks having a disproportionate impact on those from minoritised communities and people with a learning disability and autistic people.

Professor George Szmukler of the Institute of Psychiatry at Kings College London has recently critiqued sections 37/41 of the Mental Health Act for being discriminatory in relation to forensic patients compared with other offenders, due to the potential for indeterminate detention. In his view:

“A second principle follows from the need to eliminate discrimination against offenders with an impairment of mind when compared to non-disordered offenders convicted of a similar offence with a similar level of seriousness (based, for example, on the degrees of harm and culpability). The management of those with a mental impairment should be, as far as possible, on an equal basis with other offenders. Most importantly, the total duration of a deprivation of liberty (in hospital or prison) or a restriction of liberty (following discharge to the community) imposed by a sentence or court order for an offender with an impairment of mind should be no longer than that imposed on a non-disordered offender.”⁷

The government’s proposals for different detention criteria for civil and forensic patients, also meaning a differential threshold for discharge, needs further interrogation and may have unintended consequences, create perverse incentives and be discriminatory. If there is concern regarding access to treatment for those in the criminal justice system, more consideration could be given to how they may be able to access hospital treatment on a voluntary basis where they wish to do so. We are also concerned that the white paper did not support the following recommendations by the independent review in relation to forensic patients:

- Decisions concerning leave and transfer of restricted patients should be categorised by the Ministry of Justice according to risk and complexity. Straightforward and/or low risk decisions should be taken by the responsible clinician. The Ministry of Justice would have 14 days to override this decision.
- The powers of the Tribunal should be expanded so that they are able, when deciding not to grant an application for discharge, to direct leave or transfer.
- There should be a common framework for assessment of risk across criminal courts, clinicians and the Justice Secretary. The assessment needs to be regularly reviewed (at least annually and before every Tribunal hearing). Every patient should have written into the Care and Treatment Plan what their risk levels are.⁸

A more comprehensive response to improve support for people with a learning disability and autistic people

We are concerned the white paper’s proposals, whilst largely welcome, are insufficient to prevent unnecessary, and frequently traumatic, detention of people with a learning disability and autistic people. We believe a more comprehensive response, combining the following elements, is needed:

⁷ George Szmukler, International Journal of Mental Health and Capacity Law, 2020, p.40

⁸ [Modernising the Mental Health Act – final report from the independent review - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/431212/Modernising_the_Mental_Health_Act_-_final_report_from_the_independent_review.pdf) p.204-5

1. Ensuring effective national leadership and governance of Transforming Care

The Assuring Transformation data demonstrates both insufficient progress and wide variation across different geographic areas in delivery of the Transforming Care programme for people with a learning disability and autistic people. We agree with the Committee's recommendations⁹ from 2019 that clearer ministerial drive, oversight and accountability is needed to ensure milestones are reached.

2. Commissioning and planning

We welcome the white paper's proposals to create a duty on commissioners to ensure adequacy of supply of community services and the recognition of the role of pooled budgets. Consistent with NICE recommendations,¹⁰ we believe this needs to go further to address the barriers which occur between the NHS and local government. It should do this by requiring, or at least encouraging, local authorities and Clinical Commissioning Groups (or in future Integrated Care Systems) to jointly designate a single lead commissioner with expertise relating to people with learning disabilities and autistic people to oversee strategic commissioning for this population.

3. Supporting the individual and their family

People with a learning disability and autistic people who are in-patients should have a single named individual who is accountable for driving and coordinating work to ensure their discharge and keeping them informed and at the centre of decisions. Advocacy can play a critical role in supporting people with a learning disability and autistic people who are detained under the Mental Health Act. However, the availability and quality of advocacy can vary. We have set out, including in evidence to Baroness Hollins' independent review, how this could be addressed through changes to the commissioning and delivery of advocacy.¹¹

4. Investment

There is a high financial as well as an extreme human cost attached to in-patient services to people with a learning disability and autistic people. The government should recognise, however, that an increased financial investment is needed through the transition period, including double running costs, to build community capacity and capability while people remain in in-patient services.

5. Regulation

In 'Right support, right care, right culture',¹² the Care Quality Commission set out a well-considered basis for regulation of providers. Whilst the framework applies equally to new registrations and existing providers, concerns about a lack of alternative provision appear to make the CQC reluctant to make full use of its powers to de-register services which fail to meet its standards. It may be that taking a wider system approach will enable CQC to place

⁹ [Detention of children and young people with learning disabilities and/or autism \(parliament.uk\)](https://www.parliament.uk) p.3

¹⁰ [Overview | Learning disabilities and behaviour that challenges: service design and delivery | Guidance | NICE](#)

¹¹ A published paper based on this evidence is available at <https://www.voiceability.org/assets/download/Advocacy-with-people-with-learning-disabilities-and-autistic-people.pdf>

¹² [Right support, right care, right culture How CQC regulates providers supporting autistic people and people with a learning disability | Care Quality Commission \(cqc.org.uk\)](#)

more pressure on service systems to ensure that people do not remain trapped in unacceptable services.

Safeguarding human rights at the MHA/MCA interface

One of the government's objectives is to reduce the numbers of people in psychiatric in-patient settings who do not need to be there - particularly people with a learning disability and autistic people. However, the Joint Committee on Human Rights has previously concluded "that tightening the criteria for detention under the Mental Health Act 1983 could increase the number of detentions under the Mental Capacity Act 2005, with its weaker safeguards."¹³ This risk could be amplified if the government decides that greater use of the Liberty Protection Safeguards, due to come into force in April 2022, is their preferred solution to the problematic interface of the Mental Health Act and Mental Capacity Act.

A recent report by the Kings Fund into clinical decision-making at the interface of the Mental Health Act and the Mental Capacity Act found very varied practice which "raises the question about how the Acts are understood and applied individually, even before the question of how they are understood at the interface." It concluded that "the current status quo, however, is resulting in people being unlawfully deprived of their liberty and not afforded their appropriate rights."¹⁴ Change to the MHA/MCA interface is required to assist clinical decision-making which is clearly struggling with the current legal complexity.

One option would be for the Mental Health Act to be used for all those who are unable to consent or who object to psychiatric in-patient treatment as proposed by the Law Commission in 2017.¹⁵ The Mental Health Act and Mental Capacity Act have different safeguards but it can be argued the safeguards in the Mental Health Act are more relevant and appropriate for psychiatric in-patients. Subject to implementation of the proposed reforms in the white paper, those would include:

- the four guiding principles of choice and autonomy, least restriction, therapeutic benefit, the person as an individual
- regular reviews of treatment and detention including access to assessment by an independent medical practitioner (SOAD)
- ability to challenge detention and/or treatment before a First Tier Tribunal including regular automatic referral
- right to support from an Independent Mental Health Advocate and a Nominated Person who can initiate challenges to detention and/or treatment (in certain circumstances)
- access to section 117 aftercare which may help facilitate discharge
- ability to make a complaint to the CQC

¹³ [Detention of children and young people with learning disabilities and/or autism \(parliament.uk\)](https://www.parliament.uk/publications/2017/03/13) p. 52

¹⁴ [Understanding clinical decision-making at the interface of the Mental Health Act \(1983\) and the Mental Capacity Act \(2005\) \(york.ac.uk\)](https://www.york.ac.uk/inst/clinicaldecisionmaking/) p.41

¹⁵ [Law Commission Mental Capacity and Deprivation of Liberty](https://www.lawcommission.gov.uk/publications/2017/03/15) p.155